

1ST PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE

July 29, 1993



Co-Chairman Barbera called the meeting to order at 4:06 p.m. In attendance were: Co-Chairman Don Hillier, Task Force members Linda Breland, Arthur Ebersberger, Gerald Jeffein, Dr. William Lamm, J. Dennis Murray, Joan Paik, and Michael Merson. Absent were: Rosalind Griffin and Joseph Kerhart.

The Commission staff was represented by John Colmers, Arlene Stephenson, Ann Rasenberger, and Elizabeth Kameen, acting as Commission counsel.

ITEM I

Introductions and Opening Remarks

Co-Chairman Barbera reminded the audience and Task Force members that all business will be conducted in public. He urged people not to lobby individual SBPTF members and added that material addressed to any member will be distributed to all. Barbera stated that the initial meetings of the SBPTF will be fact-gathering.

If anyone has a comment on the process, Barbera asked that they contact either Don Hillier or himself.

Co-Chair Don Hillier announced the other Task Force meeting place as the Equitable Bank Center on the 17th floor in downtown Baltimore.

He stated that because of size limitations, it was impossible to have all interested parties on the Task Force. Nevertheless, he assured the audience that all views and opinions will be considered. He reminded members the deadline for their recommendations has been moved from December 1, 1993 to November 1, 1993.

Hillier also informed the members that they have a challenging assignment. They must design a package that, at a minimum, is the actuarial equivalent to a Federally-qualified HMO, but whose average cost cannot exceed 12% of the average annual wage.

ITEM II

General Discussion of Health Care Access & Cost Commission's Work

Executive Director John Colmers introduced the staff present at the meeting. He then

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defined the relationship between HCACC and the SBPTF. To ensure continuity between the two, one Commissioner, J. Dennis Murray, has been assigned to SBPTF. This practice will continue for each working group, task force, or other committee established in the future.

Colmers announced one staff would be responsible for the Commission and each of its task forces, working groups and committees.

Colmers announced that two new groups under the Commission will be named shortly. They are: the Task Force on HMO Quality & Practice Parameters Development and the Expansion of Health Care and Insurance Reform Task Force.

Colmers stated that the deadline for the Standard Benefit Plan Task Force's recommendations was moved up because of the vast amount of work required to get the product on the Market by July 1, 1994. He briefly stated the steps between the Task Force's recommendations and the July 1st deadline:

- The Commission will have the opportunity to make changes.
- The Commission shall draft regulations.
- The provider groups and insurance carriers will have an opportunity to review the regulations.
- Carriers will need time to develop new products and contract language.
- The Insurance Commissioner will have to review all new products and contracts.

ITEM III

Charge to Task Force and Requirements from HB 1359

Staff member Beth Sammis addressed the Charge to the Task Force. She outlined the following highlights of HB 1359:

- "Small Group Market" is defined as employers with between 2 and 50 employees.
- Carriers must provide a policy for all small employers.
- Industrial and medical underwriting is prohibited.
- Carriers must include all eligible employees, defined as those working at least 20 hours per week.
- As of 1/1/95, carriers may not discriminate on the basis of pre-existing conditions.
- Premiums will be calculated through adjusted community rating.

- Average cost of benefit plan may not exceed 12% annual wages.
- Benefit plan may not be lower than the actuarial equivalent of a Federally-qualified HMO.
- Mandated benefits are exempt in the development of a standard benefit plan.
- When developing the plan, SBPTF should consider:
 - medical effectiveness,
 - cost-sharing,
 - benefit plans in other states, and
 - impact on overall costs.

ITEM IV

Review of Briefing Book Contents

Ann Rasenberger reviewed the contents of the Standard Benefit Plan Task Force Briefing Book. She outlined the following:

- Covered the materials in the Table of Contents.
- 12% of average annual wage in MD equals \$3,170.
- Commission will ask Department of Economic and Employment Development to project annual wages for the coming fiscal years.
- Announced the Insurance Commission as the collector of fees, set by HCACC, to fund HCACC.

Co-Chair Barbera and Executive Director Colmers added that the 12% wage ceiling is a composite figure. The average cost of all plans cannot exceed this number. However, individual plans can be above or below the ceiling.

ITEM V

Background Information

Beth Sammis announced that she has been compiling information on benefit plans offered in the State. She also mentioned that 21 states are already in various stages of small market reform. Sixteen of those states have developed or are developing standard benefit plans.

A full report will be given at the next SBPTF meeting.

ITEM VI

Health Benefit Plan Request for Proposal

Ann Rasenberger stated ten of the sixteen solicited firms replied to the RFP. She listed some important dates:

8/3:	Selection of Actuary.
8/16:	Contract begins for six months.
9/4:	Cost out of 10 benefit plans due.
9/7:	Cost out Fed. qualified HMO regulations due.
October:	Cost out list of proposed benefits due.

Ms. Rasenberger added that the actuary would assess claims cost, not premium cost. The contractor will also determine standard overhead and load cost in order to determine premiums.

The contractor will also review contract language the HCACC and the Insurance Commission will draft. Tom Barbara and John Colmers reiterated the importance of having the benefit plan written in contractual language to save time later in the process and to ensure the Task Force of the accuracy of its recommendations.

ITEM VII

Tentative Schedule of Meetings, Hearings, etc.

Don Hillier announced the next meeting: August 5th at the MNC Financial Bank Center in Baltimore at 4:00 p.m.

The meeting adjourned at 4:56 p.m.

**2nd PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

AUGUST 5, 1993

Co-Chairman Don Hillier called the meeting to order at 4:08 p.m. In attendance were: Co-Chairman Thomas Barbera, Linda Breland, Arthur Ebersberger, Rosalind Griffin, Gerald Jeffein, Joseph Kerhart, William Lamm, MD, Michael Merson, J. Dennis Murray, and Joan Paik.

The Commission staff was represented by Ann Rasenberger, Dr. Elizabeth Sammis, Arlene Stephenson, and Elizabeth Kameen, as Commission counsel.

ITEM I

Opening Remarks

Co-Chairman Hillier briefed the audience on the agenda, focusing on Dr. Sammis's report on Benefit Plans. He noted that the report is by no means the end to the Task Force's research and the group is still open to receiving more information. Mr. Hillier announced that on August 19, the next meeting of the Task Force, employers will be asked to address the body with their concerns. If employers are interested in participating, please contact Arlene Stephenson at (410) 764-3460 or 764-3461.

Co-Chairman Barbera reiterated the importance of having small business employers testify before the Task Force. Mr. Hillier suggested that those testifying leave copies of written material for the Task Force and audience.

ITEM II

Approval of Minutes of July 29, 1993

Motion to approve minutes by Mr. Ebersberger was seconded by Commissioner Murray. The motion passed.

ITEM III

Presentation of Comparison of Health Benefit Plans

Dr. Sammis prepared a report entitled Comparison of Health Benefit Plans that reviewed 110 health benefit plans. These plans included state standard benefit plans, indemnity plans marketed by carriers in Maryland, HMO plans marketed by carriers in Maryland, plans offered by Maryland public employers, and plans offered by a few large private Maryland employers.

Dr. Sammis referred to the difficulties she faced while preparing her report. She surveyed employers and carriers in the State, but most of those who responded sent marketing material. This left important questions unanswered. They included, the definition of "medically necessary," and who controls the utilization review process. Furthermore, only four out of ten large employers surveyed responded.

Dr. Sammis began her analysis with the service categories most commonly mentioned: hospital days, substance abuse benefits, mental health benefits, infertility services.

Mr. Barbera asked if coverage for 70 or an unlimited number of hospital days were the two most common types of coverage. And if so, what makes "70" special? Dr. Sammis said 70 or unlimited coverage are both typical, but could not explain the significance of 70 days. Members of the Task Force believed that there should not be much difference in premiums between plans covering an unlimited amount of days versus 70 days since the average inpatient hospital stay was around 4 to 6 days. The Task Force asked the staff to investigate.

Dr. Sammis continued her presentation with the Maryland mandate for substance abuse. It is 30 inpatient days and 30 outpatient visits, with a \$3,000 cap on outpatient visits. Most plans reviewed did not vary from the mandate on inpatient days. Greater variation, Dr. Sammis noted, does occur for outpatient visits. Indemnity plans either restrict the number of visits or place a dollar cap on benefits. HMO's typically do not mention caps but limit visits.

Next, Dr. Sammis told the Task Force Maryland's mandate on mental health services was 30 inpatient days, 65% co-insurance for the first 20 outpatient visits, with a 50% coinsurance for subsequent outpatient visits.

Co-Chairman Barbera asked Dr. Sammis why substance abuse and mental health benefits were separate. He wondered if a person used up all of his/her substance abuse benefits could he/she begin to use mental health benefits. Rosalind Griffin replied that to receive mental health benefits, one must have an appropriate diagnosis.

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Dr. Sammis pointed out that many plans did not meet Maryland's mandates, particularly for mental health and substance abuse. She believed that carriers were taking advantage of a loophole: Carrier-established trusts in other states. Mr. Ebersberger added that companies move or market themselves in other states to avoid the mandates, as well.

Gerald Jeffein asked how many plans were avoiding the mandates. Co-Chairman Barbera said BC/BS business was 50% self-insured and 50% fully-funded plans. The self-funded plans do not have to follow the Maryland mandates. So even without out-of-state trusts, Maryland mandates are not covering large numbers of employees.

J. Dennis Murray wanted to know the cost of the mandates. Co-Chairman Barbera asked Marilyn Maultsby of Maryland BC/BS about the cost of Maryland mandates on the Blues. She said its 16%.

Michael Merson requested that the Task Force look at the Oregon Medicaid plan. He added that what is important is a weighted, or ranked, list of services. This could help the Task Force in deciding what should or should not be in the standard benefit plan.

Dr. Sammis continued her presentation with a look at infertility services. Dr. Sammis mentioned that indemnity plans and self-insured plans often do not typically mention in their marketing material if infertility services are covered. Also, standard benefit plans of other states do not specify infertility coverage.

Co-Chairman Barbera asked if in-vitro fertilization services, which are a Maryland mandate, are mandated in other states. Dr. Sammis did not know. The staff was asked to review mandates in other states, especially contiguous states such as PA, DC, VA, W.VA, and DE.

Mr. Jeffein asked if the actuary could cost out the mandates since they may impact final decisions.

Dr. Sammis continued with prescription drug policies. Dr. Lamm asked if these plans included formularies, or if there was any information on the use of formularies in the marketplace. Dr. Sammis did not know, as that information was not always available in the marketing material.

Dr. Sammis did say 6 out of 13 state standard benefit packages included prescription drug coverage. Delaware covers it, and is the only contiguous state with a standard benefit plan.

Mr. Hillier said formularies were used by large companies for long-term cost savings. He knew BF Goodrich used them, and suggested the staff ask the Maryland Pharmaceutical Association for more information.

Dr. Sammis proceeded with a discussion on alternative providers. Most plans surveyed did not mention alternative providers. Mr. Jeffein asked if that meant they were not paid. Dr. Sammis said the survey did not contain that information. Mr. Jeffein asked the staff to research that matter.

Co-Chairman Barbera asked the staff to contact the Insurance Commission for their ceiling on HMO's for copayments. He said the limits are in place to make sure costs do not deter utilization.

Mr. Kerhart said he will supply thirty-five plans which cover 60,000 employees for the members and staff.

ITEM III

Options for Actuary

Co-Chairman Barbera began discussion of the plans to be cost out by the actuary. According to the contract, the vendor will cost out the benefits of a federally-qualified HMO, as well as 10 plans that are representative of Maryland's marketplace. Co-Chairman Barbera said the goal is to "put a fence around us," in reference to upper and lower limits on costs. The Task Force would use such research as an educational tool only, and not as the basis for a standard plan.

He asked the Task Force for recommendations on the process. He suggested three options:

- prepare ten plans and submit to actuary;
- allow subcommittee to prepare plans; or
- allow actuary to select plans and cost them out.

Mr. Hillier asked if we could cover a number of deductible/co-payment variances as one plan for the actuary. He feels that altering deductible and co-payment levels should be covered under the sensitivity analysis portion of the contract.

Mr. Merson asked what the actuary was going to do in the abstract. He wondered how someone could price out various health services.

Dr. Lamm added that there should be some analysis on the relationship between hospital days and the effect on cost. Do 120 days of coverage double the cost over 70 days? What is the range?

Mr. Barbera said that in a plan, a benefit can be cost out by asking the actuary how much would be saved if something was removed. A price cannot be placed on a benefit in a vacuum.

Marilyn Maulsby of Blue Cross and Blue Shield of Maryland thought the Task Force would be giving the contractor too much policy authority if he or she selected which plans to price out.

Co-Chairman Barbera reiterated his view that these initial plans are being cost out as a learning process. They are not indicative of what the SBPTF wishes to include. Co-Chairman Hillier said this initial process is just pricing plans that are typically offered and is not making policy.

Mr. Merson believes that this initial information gathering was too important to let the contractor choose which plans to price out. He does not want the Commission to just perpetuate the status quo. Judgements on the value of various procedures and treatments will need to be made. Mr. Merson reminded the Task Force of his request for information on the Oregon Medicaid plan, to begin the process of understanding benefits.

Co-Chairman Barbera suggested a subcommittee meet to decide what plans should be submitted to the actuary. The following will have a conference call with the contractor on August 12, 1993 at 1:00 p.m.: Mr. Ebersberger, Ms. Griffin, Mr. Jeffein, Ms. Breland, and Co-Chairman Hillier.

ITEM IV

Update on Contract for Actuarial Services

Ms. Rasenberger announced the selection committee met Tuesday August 3, 1993 with the bidders. Due to the need for DHMH and other approvals, the contract will be awarded next Wednesday. She announced that the contract will begin on August 16, 1993. The contractor will address the entire Task Force at the next meeting on August 19th. Ms. Rasenberger also announced a meeting on Thursday, August 12, 1993 at 10 a.m. to discuss issues with the contractor regarding plans to cost out and other items.

Co-Chairman Hillier stated the RFP received 10 proposals. He said the selection group feels comfortable with the vendor and confident they can meet the stringent time lines.

Ms. Breland commented that prenatal care was not specified in the federal regulations for HMOs. She wanted to make sure prenatal care terminology would be specified in the Task Force's work.

ITEM V

Closing Remarks

Co-Chairman Hillier announced the dates for the two regional meetings have been switched. The September 30th meeting is on the Eastern Shore and the October 7th meeting is in Western Maryland.

The meeting was adjourned at 5:54 pm.

**3rd PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

AUGUST 19, 1993

DRAFT
9/11/93

Co-Chairman Tom Barbera called the meeting to order at 4:07 p.m.

In attendance were: Co-Chairman Don Hillier, Linda Breland, Arthur Ebersberger, Rosalind Griffin, Gerald Jefferin, Joseph Kerhart, Dr. William Lamm, J. Dennis Murray, and Joan Paik.

Commission staff was represented by: Ann Rasenberger, Dr. Elizabeth Sammis, Arlene Stephenson, and Elizabeth Kameen, as Commission counsel.

ITEM I

Approval of Minutes of August 5, 1993

Motion to approve the minutes of August 5, 1993 meeting was seconded and passed by unanimous consent.

ITEM II

Opening Remarks

Co-Chairman Barbera announced that a list of all attending guests for each previous meeting will be available at the September 9th meeting. In addition, a copy of all correspondence received by members of the Task Force will be made available by the staff. He asked the staff to keep a running list of all correspondence. He reminded the audience that all materials in the hands of the Task Force will be available for public use in a "library" on the 5th floor of the Metro Building at 4201 Patterson Avenue, Baltimore.

Dr. Sammis answered questions posed by Task Force members at the August 5, 1993 meeting.

Dr. Lamm asked the Task Force if the regional meeting scheduled for Hagerstown could be moved to Cumberland. He believed that Garrett and Alleghany Counties would be better served if the meeting was held closer to them. Mr. Hillier noted that the Commission will meet earlier the same day, and it may pose some difficulty for staff to travel. The Task Force agreed to move the meeting to Cumberland, but to start it at 6 p.m.

Mr. Hillier reported the results of a subcommittee meeting that was held on Thursday, August 12, to discuss what plans Foster Higgins, the newly-hired actuary, should cost out. The subcommittee selected real plans rather than composites based on research.

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Mr. Barbera stated that the recommendations to the Commission should be in the form of a contract. He asked Foster Higgins to help put plans in contract language. He wanted a working group setup to begin to address "stylistic changes." The work group would start drafting the non-benefit portion of the contract. The benefit portions of the contract can be drafted later. The Insurance Administration will most likely participate in the work group.

Mr. Barbera ensured the Task Force that all matters will remain public. Any work completed by this new work group will come before the Task Force for discussion.

ITEM III

Testimony from Maryland Small Employers:

Dr. Marvin Burt
President
Burt Association, Inc.
Bethesda, MD

Handles financial advice and money management; employs five people; serves on Montgomery County Chamber of Commerce Board of Directors which supported HB 1359; health plan is Optimum Choice.
What to look for in a health plan?

1) Adequacy of Coverage: wants comprehensive coverage but high copays on over-utilized services like mental health, cosmetic surgery, and in-vitro fertilization; 2) Managed Care Component: wants use of gatekeepers, economic incentives to cut costs; 3) Reputation of Insurance Firm: asks speed in which they process claims; 4) Reputation of Providers: wants to ensure quality; 5) Understandable Contract: wants language to be clear.

Dr. Burt suggested that if there were no copays, utilization would be higher.

Dr. Lamm asked about parity between Dr. Burt's mental and physical benefits. **Response:** They are different services, and thus, justify separate benefits.

Ms. Griffin asked about firm's experience with substance abuse. **Response:** None. She asked how he could make judgements on the effectiveness or usefulness of mental health and substance abuse services without any experience. **Response:** Looked at Montgomery County data.

Mr. Murray asked about the best plan for mental health. **Response:** \$25 or 50% copayment for psychiatric visits.

Mr. Barbera asked what Dr. Burt's plan is for mental health? **Response:** 50% copayment with up to 25 visits per year.

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Dr. Burt continued his testimony and spoke of costs. His annual premiums are \$11,000/year, representing a 14% increase over last year. The copays have increased \$5 per doctor's visit. In the past, he had problems getting coverage for two of his employees because of prior hospitalizations. For the past two and one-half years, his premiums have increased 133%.

Mr. Barbera asked what he would like to see in the future? **Response:** Satisfied with Optimum Choice because of lower costs, coverage concept is better, but copays are higher than he wants; dislikes geographic limitations, only covers outside immediate area if injury is life-threatening.

Ms. Griffin asked what areas should be improved? **Response:** Out-of-pocket maximum's should be lowered, out-of-area coverage should be increased, risk should be spread, some exclusions deleted.

Mr. Barbera asked what choice would Dr. Burt prefer between higher copayments and lower premiums? **Response:** It would be nice to have a choice between higher rates and lower copays, let the private sector decide. The largest overhead expense, behind salaries, is health insurance. It would be nice to shift some more responsibility to the employee.

Mr. Kerhart asked how Dr. Burt is rated? **Response:** We have five members in our group. Mr. Kerhart stated his support for higher accessibility for mental health and substance abuse because it saves money in the long run.

Mr. Jeffein asked how many families were in Dr. Burt's plan? **Response:** 2 families, but employees pay for family members.

Ms. Peggy Starr
Merex
Montgomery County

System Integration firm which employs 40 people and pays \$80,000 in health insurance premiums per year; relatively young, healthy workplace; enrolled in Optimum Choice; looked at deductibles, limits, family benefits, stability of company, among other reasons for selecting MD/IPA.

Concerns with process: 1) Amount of time to research different plans; 2) After entering plans, premiums

went up 40% because one employee had a cancer scare, later found to be no problem; 3) Geographical coverage; 4) Amount of paperwork after plan is selected; 5) Unknowns are problems; 6) Importance of well-baby care; 7) Waiting period for new enrollees.

Mr. Jeffein asked if firm was experience-rated? **Response:** Yes.

Ms. Griffin asked if firm had any experience with mental health or substance abuse usage? **Response:** One drug abuse experience, but employee never used the plan.

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Mr. Walter Finkelstein
President
FAI
Rockville, MD

High-technology firm employing nine people; provide health coverage for four employees with nationally-recognized carrier; yearly premiums are \$36,000 including families; chose expensive coverage to attract most talented employees; most business is by federal contract so plans must meet minimum mental health and substance abuse benefits; company was as big as 45 employees with an average age between 25-50,

today, average age is 42; firm pays \$750 per family; firm would like to be in a larger pool; increases have been moderate but fears next year will be high because of \$100,000 claim by an employee's spouse; had a 7.6% increase last year, expects increase of \$1,000/month for that one employee; looked at PPOs and HMOs but they didn't afford employee flexibility for personal physician; he has "Cadillac" coverage.

Ms. Breland asked what "Cadillac" coverage meant? **Response:** Indemnity plan where employees pay no premiums but \$36/month for dental. They have a \$250 deductible, \$1500 out-of-pocket maximum, \$5/\$10 for generic/name brand prescription drugs.

Dr. Lamm asked does coverage affects utilization? **Response:** No employee sees the effects of over-utilization or the "bottom line" because he operates like a family. Few people have "taken a hit" on insurance claims.

Office of Economic Development in Montgomery County is working on a new plan which should be helpful.

Mr. Hillier asked if firm was experience-rated? **Response:** Yes.

Mr. Richard Pouliot
Applied Specialty
Beltville, MD

Engineering firm, covers all employees; started offering health insurance in 1970 from Metropolitan Life because he had a friend who would write the policy; average longevity with a carrier is 3 1/2 years; had indemnity plans, PPOs, HMOs, and is with George Washington Health Plan now, switched from Capital Care; firm buys health insurance for

consortium of four businesses employing between 21 and 41 people.

What should be in a health plan? 1) Benefits; 2) Portability; 3) price stability.

In pricing out last switch, firm researched a number of plans. Average premium for similar coverage range from: \$137-\$183 for one employee per month; \$320-\$537 for family. He would like to know the reason for such variation in price.

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Would like to see: 1) Copays indexed for inflation; 2) No copays for preventive services; 3) Better geographic portability for travelers; 4) Reduction in administrative costs, witnessed physician group with three doctors, two nurses, and six administrators.

Wants mental health and substance abuse coverage. No discrimination. If copays are high for such services, nobody will stay with rehabilitation program. Firm had 35 drug addicts in Construction Company, had only one recovery. People couldn't afford 50% copay for \$100 visit. The one who recovered had treatment paid in full.

Mr. Barbera asked if Mr. Pouliot requested lower copays for mental health and substance abuse? **Response:** Yes, but it is not available from the plan most of his employees are in. However, four employees are covered by Colombia because of location of residence, and they pay less and get more coverage for diabetes care, mental health and substance abuse.

Mr. Pouliot ended with some advice regarding the insurance plan purchasing process- Hire a professional to shop for your firm.

Mr. Sheldon Grosberg
Vice-President for
Administration
Ruth Rider, Inc.

Company runs SASSAFRAS, a clothing outlet which employs 400, 125 of which are full-time; for the past five years, his insurance rates have increased: 40%, 20%, 30%, 12%, and 14%; five years ago, his indemnity plan with BC/BS had \$50 deductible and covered 100% hospitalization; today, there is a \$500 deductible and an 80%/20% coinsurance in his

PPO/indemnity plan; firm did not want an HMO with a specific doctor and facility.

Concerns: 1) increase cost to company because at least one incident each year, or pregnancy make premiums go up; 2) most part-time employees cannot afford health insurance even if firm partially covers it; 3) Firm is having problems switching people to the in-network PPOs because they want to stay with their doctors, especially women and their OB/GYN's; 4) Current plan has out-of-pocket max at \$2,500, copays at \$5, \$10, \$25, or a coinsurance of 20%; 5) Indemnity plans do not cover preventive care; 6) The firm's premiums are: \$178/month, \$535/family, \$167 Medicare supplements.

Mr. Kerhart asked how many part-time employees have health insurance? **Response:** 30-35%. There are a number of single parents who work less than 20 hours per week. The firm offers to pay 50% of employees' premiums, but most can't afford it. Currently, there are 125 employees on the health plan, including some COBRA and Medicare Supplements.

Mr. Grosberg added that it is impossible to predict annual increases in cost because every incident affects plan. This makes it difficult to run a business.

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Mr. Chip Berman
Out-of-the-Way-Cafe
Ms. Linda Deffinbaugh
Fred & Harry's Seafood

Mr. Berman and Ms. Deffinbaugh represent the Restaurant Association; Mr. Berman addressed the Task Force on reasons why many restaurants do not provide health care; restaurants are the largest employers in Maryland outside of government; 136,000 people, or 7.6% of the population; there are 7,000

restaurants, but only 49% provide health care; 75% make less than \$500,000 in sales and are single units; 33% are sole proprietorships; 39% of costs in a restaurant are labor; employees produce economic output of only \$31,000 per year; nationally, restaurants make 3.5% profit, in MD it is only 2%; each employee generates only \$700 in profits.

Here, it is a question of health care versus jobs. In a sense, it is not profitable for a restaurant to provide health care when the employee does not produce enough profits to balance the costs.

Ms. Deffinbaugh testified as to her health insurance experience. She covers 14 employees, but not the 30 part-time; lost \$12,000 last year, but kept insurance coverage; health costs went up 30% last year; plan has a 60%/40% co-insurance; advocates stronger mental health and substance abuse coverage, with some copays, but not as high as 50%.

Mr. Barbera asked if Ms. Deffinbaugh understood that lowering the co-insurance from 50% would result in higher premiums? **Response:** I understand.

Mr. Hillier asked Mr. Berman if there was a price at which he would provide coverage to his employees? **Response:** There is nothing left that is affordable.

Mr. Murray asked Ms. Deffinbaugh how we could care for sick people? **Response:** I would like a "cafeteria" plan, or a section 125-D, which allows one to use pre-tax wages.

Mr. Hillier described the "cafeteria plan" as being similar to a salary reduction, since the money is spent before payroll taxes.

Mr. Russ Glickman
President
Glickman Design/Build
Rockville, MD

Mr. Glickman has fifteen employees and is speaking on behalf of SHARE. Five years ago, his son was born premature, with cerebral palsy, and was hospitalized for six months. His family caused premiums to go so high, he had to insure his family separately from his employees. Eventually, he was able to be covered by Optimum Choice, the plan used

by his employees. His premium is \$1,500 per month for a family; there are ten employees on the plan at a total cost of \$36,000, up 17% after the first year.

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List of problems with plan: 1) His son has cerebral palsy, the insurance company covered a \$5,000 electric wheelchair but not a \$300 stroller; 2) The UCR is generally only 50% of total cost; 3) Physical therapy is covered for only 50% for 50 visits; 4) Pre-existing condition limitations; 5) Mental health and substance abuse coverage are weak; 6) Exclusions, like organ transplants, are bothersome.

He is happy with: 1) Prescription drug plan; 2) Reasonable deductible (\$250 with an out-of-pocket maximum of \$1,250); 9) Speed in which claims are paid; 3) Ease of usage in-network.

The average age in firm is 32 years. Advocates an "Arbitration Board" to oversee complaints over what is or is not covered. He also recommends a change in the pre-approval process for claims.

Ms. Jill Groce
President
Editorial Consultants

Ms. Groce is self-employed and does not have health insurance; Vice-President of Association of Home-Based Businesses; in 1988, she paid \$102/month, in 1990 it rose to \$120/month, followed by an increase of 15% two years in a row; dropped her health insurance in April, 1993 when the premiums rose to \$225/month.

Mr. Barbera asked if Ms. Groce's Association formed a group? **Response:** Not at this time, but the industry is growing so fast, that may be an option in the future. She has given up hope for seeing her own physician.

She met with Kaiser, whose premiums would be \$143/month, but the patient must be in perfect health to join. Her best choice right now is to own a catastrophic plan that covers 100% after \$10,000.

ITEM IV

Report from Actuarial Consultant, Foster Higgins

Mr. Barbera introduced Mr. John Lynch, an analyst from Foster Higgins.

Mr. Lynch addressed the Task Force on his role: to assess economic reality. He listed two of his main goals: 1) Price out federally-qualified HMOs; 2) Quantify plans to reflect the Maryland marketplace.

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Mr. Barbera asked how one could compare benefit plans? **Response:** Mr. Lynch recommended looking at various delivery systems:

- Federally-qualified HMOs
- Non-federally-qualified HMOs
- Preferred Provider Organizations
- Indemnity Plans

Then he suggested looking at reasonable cost-sharing.

Mr. Barbera asked Mr. Lynch to price out at least one plan with parity between mental and physical health benefits.

Dr. Sammis reminded the Task Force that the first set of plans are to accurately reflect a cross-section of the marketplace, and that various other issues, like parity, should be addressed in September.

Mr. Barbera agreed.

Mr. Jeffein asked for a clarification of the Task Force's mission.

Mr. Hillier replied that the Task Force must provide the "floor" for plans offered in the small marketplace.

Mr. Barbera suggested the Task Force submit four standard plans to mirror each of the delivery systems.

Dr. Sammis added that the first set of plans the actuary will cost out should be typical plans currently offered, and that in September, the Task Force will price out plans with specific benefits.

Mr. Barbera asked if the Task Force could eliminate the Point-of-Service plan.

Mr. Lynch replied that the Point-of-Service plan is just a term referring to a network. If an employee uses a network, he or she receives more benefits. In the Point-of-Service plan, the employee has the choice to go out-of-network. This plan may use a gatekeeper.

Dr. Hal Cohen outlined three levels of service:

- in-network with a gatekeeper
- in-network without a gatekeeper
- out-of-network

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Mr. Barbera introduced Dr. Cohen as the past Executive Director for the Health Services Cost Review Commission, a consultant to the Health Care Access and Cost Commission, and a future Commissioner.

Mr. Lynch reminded the Task Force that currently thirteen plans are in his possession and that only a maximum of ten plans can be costed out. He asked the Task Force to choose, or let Foster Higgins choose the final set of plans.

Mr. Ebersberger asked about picking a staff model, like Kaiser, to cost out.

Mr. Hillier asked if Foster Higgins could choose ten cross-sections of the market.

Mr. Barbera suggested Foster Higgins cost out one staff model HMO, one IPA, one or more Point-of-service, one PPO, and two or three indemnity plans.

Mr. Kerhart asked how the self-insureds fit in to database Foster Higgins is using.

Mr. Lynch replied that he is looking at designs, mandated benefits vs. non-mandates.

Mr. Ebersberger noted the shortcomings of the Delaware Standard Benefit Plan, with so many caps on services.

Mr. Lynch replied that there were no assurances that the price would equal the eventual marketplace version. Ultimately, the vendors will decide what the plan is worth. He also said that he will identify claims and non-claims costs. The ceiling will include total costs.

Mr. Jeffein asked about the mandates.

Mr. Barbera replied that most mandates did not apply to HMOs and that HB 1359 did not address the current mandates on HMOs, like 365 hospital days.

Mr. Hillier said that 90% of the self-insured plans he had seen covered most of the Maryland mandates anyway.

Mr. Barbera responded that the mandates do not allow copays or deductibles, as they may have in the self-insured market.

Mr. Murray asked if the actuary needed more input.

Mr. Lynch replied Foster Higgins will work with the current materials. He also said that they will contact the Task Force members in the next few days.

Mr. Barbera announced that Mr. Ebersberger will chair the subcommittee working with the actuary on reducing the number of plans to under ten.

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Mr. Jeffein asked the actuary if his database would be specific to certain variables, like whether or not the coverage included families.

Mr. Lynch responded that he has an age-based, sex-based curve that models Maryland's small employer market. It will be built with existing national databases.

The meeting was adjourned at 7:00 p.m.

4th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE
SEPTEMBER 9, 1993

Draft
9/23

Co-Chairman Don Hillier called the meeting to order at 4:17 p.m.

In attendance were: Co-Chairman Thomas Barbera, Linda Breland, Arthur Ebersberger, Rosalind Griffin, Gerald Jeffein, Michael Merson, Joseph Kerhart, Dr. William Lamm, J. Dennis Murray, and Joan Paik.

Commission staff was represented by: John Colmers, Ann Rasenberger, Dr. Elizabeth Sammis, Tom Murray, and Elizabeth Kameen, as Commission counsel.

ITEM I

Approval of Minutes of August 19, 1993

Motion to approve the minutes of August 19, 1993 meeting with technical changes was seconded and passed by unanimous consent.

ITEM II

Opening Remarks

Co-Chairman Hillier welcomed the audience and announced the format for the hearing and introduced both representatives from Foster Higgins, John Welch and Don Gespaco.

ITEM III

Report from Foster Higgins

Mr. Welch distributed copies of a report prepared by Foster Higgins outlining the costs associated with eight "model" plans and one federally-qualified HMO. The eight plans were selected to best represent the current market with two plans from each of four delivery systems: Indemnity, PPO, Point-of-service and HMO. Plans were also selected for variances in cost-sharing.

Mr. Welch introduced Mr. Don Gespaco who led the Task Force through "Health Care Economics 101."

He began by describing the cost of health care as a function of price and volume. Delivery systems provide incentives for providers to affect either price, volume, or both. This leads to cost-shifting.

Mr. Welch referred to a report prepared by Foster Higgins describing the preliminary costs of four typical plans.

A provider receives almost no profit from Medicare, the Blues. Most profits come from the private insurance market, or the commercial payors.

Mr. Hillier commented on the plan selection process. The plans were typical, offered all state mandates, varied in cost, and were representative of the four different delivery systems.

Foster Higgins used a number of databases and surveys to determine their cost projections, including one survey which covered 34 Maryland employers and over 180,000 people. They used information from carriers as well.

Mr. Gespaco explained the mathematical details involved in the process. He described the use of models adjusted for the small group market, adverse selection, and demographics (younger employees).

Dr. Lamm asked if community rating will eliminate adverse selection. Mr. Gespaco responded 'no' because employers can select against the plan.

Mr. Welch added that he heard those concerns at the last meeting, where coverage was too expensive. As long as employers have the choice against the plan, adverse selection will exist.

Mr. Jaffein asked if a small employer had an advantage over a large employer based on adverse selection? Mr. Welch replied that large employers have all the data and rating information on their employees, whereas small businesses do not.

Mr. Barbera asked about community rating. He suggested that if a small group anticipates cost, they will purchase insurance, and the following year, rates will go up. This leads to adverse selection through experience rating. Would this be more likely under community rating? Mr. Gespaco replied there would be less adverse selection.

Mr. Barbera commented that if one anticipates cost, you will stay in the plan longer. Mr. Gespaco replied that others would drop out of plan because it will become too expensive.

Mr. Gespaco referred to the key issues:

- Trend, moderate
- Greatest differential is delivery system. Discounts can be negotiated on out-of-hospital costs.

Mr. Gespaco addressed some additional factors, like co-pays. He said they have an impact on the price of a program.

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Mr. Welch referred back to the report, and described the sliding scale of costs between various delivery systems. The indemnity plan is most expensive, down to the HMO.

He also added that the minimum package is already at the 12% average annual wage level.

Mr. Jeffein asked about costs for individuals, rather than groups, as was written in the report. Mr. Welch replied that down the road, Foster Higgins could do that analysis.

Mr. Colmers reminded the Task Force that insurance carriers will price the products out themselves.

Mr. Merson asked about national trend data. He noted that delivery systems are changing and because of it, he did not like the way the plans are currently configured. He used as an example the point-of-service plan. Some plans, like HMOs with a point-of-service wraparound are being replaced by integrated P.O.S. plans. These are performing at identical cost to classic HMOs.

Mr. Hillier responded that these plans are indicative of how they are currently offered, not projecting into the future. That depends on the creativity of the design.

Dr. Lamm asked how much of the costs are profit, and how much for administrative costs. Mr. Welch said they used a 70% loss ratio, or the amount actually paid for claims. The other 30% includes profit, costs, overhead, etc.

Dr. Lamm asked if that was an accurate figure. Mr. Welch said that figure could go down to 25%, or even 20% based on the marketplace. The hope is for aggressive competition in the small group market.

Dr. Lamm also asked how much costs would be if there was community rating right now? Mr. Welch replied that these figures assumed community rating.

Mr. Colmers reminded the audience that this was a draft report. There were a series of assumptions built into the analysis and Staff will look at reasonable modifications. These are also simply draft numbers, and not for public distribution.

Mr. Merson added that 85% of care is HMO part of the Point of Service. Now it is 90%. He believes this could have an impact.

Mr. Hillier announced that Mr. Jeffein brought copies of section 125 for the Task Force.

Mr. Jeffein described the section which allows employers to pay premiums before taxes. Employers could save 8.65% under this program.

Mr. Hillier then introduced Beth Sammis, who spoke of the regional meetings. Dr. Lamm

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reminded the members that the October 7th meeting would be held at the Memorial Hospital and Medical Center of Cumberland. Dr. Lamm stated that he reserved rooms at the Holiday Inn in Cumberland for those wishing to spend the night.

ITEM IV

Testimony on Mental Health Services:

Mr. John O'Brian
Department of Health
and Mental Hygiene

Mr. O'Brian works for the Department of Health and Mental Hygiene and staffed the Mandated Benefits Committee. This committee made recommendations and prepared reports concerning mental health and substance abuse mandates in the State. The Committee's findings include: mandates promote efficiency in the market, mandates save money, dollar limits are not useful, and exceptions for HMOs are not

justified. Mr. Merson asked if Mr. O'Brian had any recommendations. Mr. O'Brian responded "no," but the legislature should work with the analysis.

Ms. Debbie Ancorage
Ch. MD Social Workers
Nancy Alexander Assoc.

Ms. Ancorage is a social worker and made five recommendations on substance abuse benefits. They were: treatment is proven effective, utilization is affected by coverage, outpatient services are effective, there is potential for managed care component, and copays are a factor in utilization.

Mr. Hillier asked about Ms. Ancorage's thoughts on mandating benefits. Ms. Ancorage replied that mandates would restore incentives to the marketplace.

Ms. Alice Nealy
MD Psychological Assoc.
MD Psychiatric Assoc.
MD Nurses Assoc.

Ms. Nealy introduced a panel of mental health providers. They included: Casey Hughes, a psychologist, Dr. Sandra Benter, Psychiatric Council of MD Nurses, Larry Cline, Psychiatric Society, Donna Wells, a social worker, and Lanny Morrison, owner of various hospitals.

Ms. Nealy noted her role as the representative of mental health providers. Mr. Hughes began the testimony with an assessment of mental health. Mr. Hughes argued the current state of mental health is inadequate. He recommended the Task Force to prohibit discrimination against mental illnesses. He asked for coverage based on objective decisions,

applicable to all health care. The only exception being for life-threatening situations. He asked the Task Force not to "shirk" its responsibility.

Second, the Standard plan should be the same for all carriers. The intent of HB 1359 made it clear that we would have a uniform benefit plan, not one for HMOs, one for PPOs or indemnity plans.

Mr. Hillier asked about Employee Assistance Plans, where employees get first contact care at no cost. He asked the panel to address these new programs.

The panel agreed to address the issue during later testimony.

Dr. Benter revealed that 20% of all Marylanders will experience a mental health problem. She added that suicides account for a large number of cases. According to the Office of Technology Assessment, 4.9% of people are in jeopardy of a major depression. Also, 12% of children age 18 and under require mental health services, and 50% of mental health patients also have substance abuse problems.

Dr. Benter reflected the success rates of mental health patients:

- medication and rehabilitation reduce relapse rates;
- 60% of Substance Abuse cases are treated within one year;
- 89% of psychotherapy patients are helped;
- 80% of panic disorder patients are successful.

Mr. Cline of the Psychiatric Society ran through the history of mental health benefits in Maryland and related it to costs. They began in 1960 as a state mandate. The costs were high originally because the provider community was not prepared for the large number of young drug offenders. Inpatient costs were high, but now, that has stabilized. The substance abuse benefits are controlled in terms of costs due to a better understanding of needs by the providers.

Ms. Wells, a practicing social worker, emphasized that failure to provide outpatient services leads to hospitalization, and ultimately, higher costs.

Mr. Morrison, the mental health hospitals owner, rebuked some research on costs due to false assumptions. He said the Clinton folks used 1988 projected numbers to factor in mental health costs. Mr. Morrison said those costs are inaccurate since the growth in mental health managed care has seen reduction in costs.

He also commented on Employee Assistance Programs as a significant cost saving and benefit-providing structure. At a cost of \$1 a month per employee, companies like McDonald Douglas have saved 34% of costs from fewer employee sick leaves, and a more productive workforce. Unfortunately, EAPs are not an alternative for the small group market, since they do not have enough employees to cover costs.

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Mr. Hillier asked if EAPs should be a part of the benefit design. Mr. Cline argued that there may be some concerns on confidentiality. He was reluctant to see it mandatory for an employee to see an EAP for a referral if a mental health visit is needed.

Mr. Ebersberger asked about the CHAMPUS experience, if they could only use federal facilities? Mr. Morrison replied that they are allowed to seek his services.

Mr. Ebersberger then asked if he could expand on any legislation that passed this year on parity between mental and physical health benefits. The panel replied that Georgia passed such a provision in 1986 but never implemented it.

Mr. Ebersberger thanked the panel for its numbers on costs, and suggested Foster Higgins, the consultant, should cost the final numbers out.

Mr. Hillier asked the panel to share any data or information with Foster Higgins.

Mr. Merson commented on the scope of the mental health coding manuals. He said there was no prioritization, and that he saw an inability to control mental health costs.

A panelist responded that the codes are similar to those for physical illnesses. Managed care groups in MD have done well with mental health benefits.

Mr. Merson asked where objective criteria fit in? Mr. Morrison said Utilization Review does exist for mental health.

Mr. Colmers asked how the SBPTF could possible rank or prioritize mental health and physical health benefits together by November 1st? The panel replied that Oregon, in its ranked list, incorporates both mental and physical benefits.

Mr. Colmers also asked to clarify their message, if in fact mental health and substance abuse benefits are indeed managed? The panel replied, "yes."

Dr. James Hutchinson
Mental Health Provider

Dr. Hutchinson spoke of the number of people who need mental health services. On borderline personalities, 7-10% commit suicide. Those people suffering from depression and are over 55 are more likely to die. Costs are low for services since it is a low-tech situation. The only costs are those associated with the provider. It is one-on-one dialogue.

Mr. Barbera asked what the limit should be for inpatient services. Dr. Hutchinson replied that at least 50% of costs should be covered for six visits, and 75% for less than twenty-two

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outpatients visits.

Dr. Lamm suggested that his experience validates the cost of mental health treatment. He said we must come to grips with society's attitude that emotional ills are not OK. If intervention and treatment is early, it will save costs down the road.

Dr. Alan Schusterman
MD Managed Care
Association

Dr. Schusterman represents the Maryland Managed Care Association which currently serves 1.2 million people. He pointed out the shortcomings of covering such services in the past: inconsistency of providers and their treatments for similar conditions; unethical practices of some facilities.

Managed care programs can cover all people in the United States for both inpatient and outpatient at an increased premium cost between 6-8%. These managed programs are not like HMOs.

Costs are saved because new facilities not hospital professionals have changed, effective drugs have been introduced, there is a developed care infrastructure, and price deflation has occurred in fees.

He asked SBPTF to offer general parity. He asked for at least 30/60 days of inpatient care, and 30 outpatient visits. In addition, he wanted "medically necessary" to be defined.

Mr. Barbera asked who the members of his Association were? Dr. Schusterman replied: Greenspring, Options Mental Health, Physical Therapists, and HMOs.

Mr. Barbera also asked why lower outpatient visits than inpatient days? He replied that treatment for most severe cases involve jumps in and out of hospitals.

Mr. Murray asked the average length of stay in MD hospitals. The answer is 5-12 days for physical illnesses. Dr. Schusterman said psychiatric hospital days are cheaper.

Ms. Marsha Pines
Alliance for Mentally Ill
Chair, Health Resources
Planning Commission

Ms. Pines began with a call for parity between mental and physical benefits. She asked the Task Force how many knew people with a mental illness. She said 25% of all families deal with such issues. Long-term treatment is expensive, but Ms. Pines noted treatment is getting cheaper. Average length of inpatient stay is 11-15 days. SB 389 (Mental Health Parity Bill)

prohibits discrimination.

Randy Lutz
Former Assist. Attn. Gen. ('75-84)
Mental Health Association of MD

Mr. Lutz testified that discrimination of mental illness by health plans is absurd. The practice of discrimination is a new event for insurance companies, and was not done in the past.

In 1990, ADA list mental illness as a disability. A standard benefit plan that does not have parity could violate the ADA. Mr. Ebersberger stated if there was parity than we would be forced to change the affordability provision. Mr. Murray stated federally qualified plans would have to meet ADA standards. Mr. Hillier clarified that the Task Force was dealing with the actuarial equivalent of a federally qualified HMO.

Dr. Lamm asked if we could devise something Foster Higgins could not cost out. Mr. Hillier stated that they can model any plan, but the confidence intervals will change depending on the certainty of the underlying assumptions.

Mr. Kerhart reminded the group that we cannot loose sight of making the product affordable. Mr. Barbera said we must be realistic. Small employers will have to buy this or nothing. If the product is priced too high, we could create more uninsured people.

Bobbie Seabolt
Academy of Pediatrics

Ms. Seabolt stated mental health coverage important for children and adolescents. Care should be early, enough, easy to access, and flexible. Flexibility is more cost effective and better for the patient. She believes coverage should be as long as

necessary. Mental illness is the childhood disease we have not cured: homicides, suicides, teen pregnancy, learning disabilities, and substance abuse. She called these the "new morbidity."

Nancy Alexander &
Stephen Buckingham
MD Society of Clinical Social Work

Ms. Alexander stated she is Chair of MD Social Work Coalition and is speaking for clinical social workers. She believes mental illness is a big problem because it affects many people (20% of the population). When looking at the cost of care, one must also look at the costs that care off-sets such

as savings on unemployment, crime, physical illness, etc. If problem not addressed in insurance, problems goes to the public sector in the form of welfare, Medicaid, and prison.

Ms. Alexander stated she wants mental health to have parity with other services in benefits, co-insurance, deductibles, access, and freedom of choice. She believes there is no valid

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distinction between mental and physical illness. She stated that social workers treat 65% of the mental health problems but one quarter not reimbursed.

Mr. Buckingham had two points: 1) The impact of mental health services on offsetting social and economic factors must be quantified. 2) Monetary disincentives (co-pays, etc.) are not the only barriers to service. Other barriers that prevent people from getting service include gate-keeper problems, provider limits, UR review, and pre-authorization.

Mr. Jeffein stated that small businesses cannot bear the cost of society's ills. Such problems are beyond the scope of the Task Force.

Marion Pokrass
Coalition of Mental Health Professional
& Consumers

Ms. Pokrass stated she was full-time social worker specializing in Alcoholism and represents a coalition of consumers and providers. Coalition formed to lobby the Clinton Administration on national health insurance. She stated that privacy and

confidentiality were especially important in treating mental illness and that the managed care industry destroys privacy and ruins mental health treatment.

She believes any standard benefit bill will be "defacto" shrunk by the managed care companies by their efforts to arbitrarily limit or terminate treatment. She also believes privacy and confidentiality are violated in authorization efforts and in the files of the health plans. She then gave several vignettes of people who had conflicts over services with their HMOs.

ITEM V

Testimony on Prescription Drugs:

Ellen Franklin
Pharmaceutical Manufacturers Assoc.

Ms. Franklin urged that prescription drugs be included in the benefit package. By covering drug therapy, we avoid costs of surgery and other interventions. If drugs are covered should have some cost sharing

as other services decrease. She stated that drugs should be covered for all listed uses and not some subset in a government formulary. Good drug usage could be assured though drug UR.

Her concern over cost sharing is that there not be a high front-end deductible before drugs are covered. Also concerned that payment levels not be keyed only to generic drugs when brand names are determined to be needed. Insurance needs to pay for cost-effective

therapy, and this includes drugs.

Dave Miller &
Frank Palumbo, MD
MD Pharmacist Association

Mr. Miller believes plan needs some sort of drug coverage. He wants a deductible like the Clinton plan that has up to a \$250 deductible separate from medical. He stated that the average patient uses 6 prescriptions a year at \$30 each. Therefore

most people would be under the deductible. However, the deductible would be there to protect the elderly, AIDS patients, etc.

Mr. Miller provided three riders in the exhibits of his written testimony to show ways of covering drugs. The Pharmacist Association opposes caps. It would rather see a deductible in order to eliminate most people but to allow catastrophic coverage. He favors cost sharing that brings the patient into the drug decisions. This will make patients more cost sensitive and compliant in drug therapy.

Dr. Palumbo stated if the plan covers drugs it should also recognize the services of the pharmacist. Pharmacists are highly trained professionals who provide valuable clinical services. The pharmacist is the key person in the process and the final point before the drugs goes to the patient. He urged the Task Force to think how we can pay the pharmacist for services, whether or not a drug is dispensed. For example, the pharmacist finds the drug is unnecessary or inappropriate.

Frank Olsen
MD Association of Chain Drug Stores

Mr. Olsen believes all plans should have drug coverage. He believes that a deductible with no upper limit is the best way to proceed. He plans to submit a plan to the task force.

The meeting adjourned at 7:50 p.m.

5th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE

SEPTEMBER 17, 1993

Draft
9/23/93

Co-Chairman Don Hillier called the meeting to order at 3:15 p.m.

In attendance were: Co-Chairman Tom Barbera, Rosalind Griffin, Gerald Jeffein, Dr. William Lamm, and Joan Paik.

Commission staff was represented by: John Colmers, Ann Rasenberger, Dr. Elizabeth Sammis, Tom Murray, and Elizabeth Kameen, as Commission counsel.

ITEM I

Opening Remarks:

Mr. Hillier asked all testifiers to limit remarks to five minutes.

Mr. Barbera announced that the next meeting of the Task Force will be a working session. One objective is to give Foster Higgins a design for the plan. The public is invited, but no testimony will be heard.

Mr. Hillier emphasized the importance of the next meeting.

Mr. Colmers viewed this meeting as an opportunity to "narrow the universe." First there will be a range of plans to price out, followed by an opportunity to refine various benefit designs.

Mr. Hillier asked the Task Force to keep Saturday October 23rd and, if necessary, October 30th open for day-long meetings, in light of the amount of work still left to complete.

Dr. Sammis reported the "Confidential" Clinton benefit design draft was available as a resource for the Task Force.

Mr. Hillier reported that Sally Duran of Kaiser is heading an ad hoc group to draft contractual language. He read a letter regarding her group's meeting on September 24th, and left a number for those interested in attending. It is (301) 816-6452.

Testimony from Maryland Citizens:

Ms. Dunnells introduced her colleague, Mr. Jim Turnock. HMOs in Maryland serve almost 1.3 million citizens, which accounts for a 27.5% market share. It has quadrupled in four years because, in part, Maryland wants preventive care.

Her recommendations are outlined in a packet, and are:

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Ms. Geni Dunnells
MD Assoc. of HMOs

- 1) Preventive services are important.
- 2) Modest cost-sharing, copays should be allowed.
- 3) Don't be too specific on what preventive services should be covered, since technology, and other factors, change.

HMOs have an incentive to keep people well, and rely heavily on primary care doctors to coordinate services.

Also, HMOs have a nominal copays, which reduces the cost barriers to care.

Mr. Turnock is VP of MAHMO and works for CFS Health Group, which operates four HMOs. Their services include:

- 1) Prenatal care.
- 2) Back-to-School physicals.
- 3) Cholesterol Screening.
- 4) Pap smears.
- 5) Other preventive services.

HMOs generally reach out, educate members to keep well.

Mr. Jeffein asked the average cost of the preventive program? Mr. Turnock replied, "I don't know," but did say HCFA estimates costs at \$100/patient/year. Ms. Dunnells said she will provide those costs to the Task Force.

Mr. Hillier asked if savings are more than spending? Ms. Dunnells said yes, and that studies on prenatal and low birth weight babies are scientific indicators.

Mr. Hillier added that he is wrestling with preventive services. He knows they are good medicine, but the costs are now, but the savings are later. How could the Task Force indicate that in the package?

Ms. Pat Cornish
MD Federation of Business
and Professional Women

She represents 12,000 members. MD has one of the high breast cancer rates in the country. It is critical the Task Force include mammograms, pap smears, and pelvic exams. These early detection services save costly procedures in the end.

care.

She also encouraged counseling services for family planning and a guarantee for basic reproductive health

Ms. Priscilla Hart
League of Women Voters

The League of Women Voters has completed a study on health care in which they encourage insurance for all citizens. That plan includes prevention, child inoculations, eye exams, women's services, including abortion, family planning, and counseling.

Dr. John Southard
Director, Chronic Disease
Prevention, DHMH

Dr. Southard reviewed an approach to providing preventive health services. He encouraged the Task Force to only include services that are proven effective. The Task Force can use the Guide to Clinical Preventive Services as a resource.

Dr. Southard also encouraged the setup of a Technical Advisory Committee to review services offered.

Mr. Hillier asked if he meant now or later? Dr. Southard asked that it be setup like the Health Services Cost Review Commission.

Dr. Lamm asked if this advisory committee could fall under the practice parameters advisory group referred to in the statute. Dr. Southard said yes.

Ms. Griffin asked if he would leave some leeway for promising developments, or only those services that have been clinically proven effective? Dr. Southard replied only those proven effective.

Dr. Lamm asked if DHMH had programs to educate the public on preventive services? Dr. Southard said yes, and that he plans to start a program through physicians.

Ms. Bobbi Seabolt
Ms. Amy Blank
Mr. Hal Gross

Ms. Seabolt represents the MD Academy of Pediatrics and introduced Ms. Amy Blank, representing the Advocates for Children and Youth.

Ms. Blank said her group focuses on the 0-5 age group, to ensure they are prepared for school. It is a coalition of providers, activists, and businesses.

She would like to see preventive services before classes begin for children.

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Ms. Seabolt asked the Task Force to look at the federally-qualified HMO regulations and see what is disallowed. She recommended no cuts in the current package, and to cover pre-natal care.

Mr. Colmers asked if they are currently covered. Ms. Seabolt said yes, although they are not explicitly mentioned in the regulations.

Some problems she noted were: baby discharge at 24 hours, and lack of home visits for pediatric consultation.

She recommends that a 2-5 day physician visit be covered right after child is born.

Ms. Blank encouraged home visits to handle post cardem depression, substance abuse, and other possibilities.

Ms. Seabolt also strongly encouraged the inclusion of family planning, and not to discriminate against Norplant, and other devices.

In addition, they requested:

- 1) Eyeglasses for children in school.
- 2) Dental services.
- 3) Rehabilitation services for children with disabilities.

Mr. Hillier asked if she consulted the dental providers? Yes, they support it.

Dr. Lamm asked for suggestions on copays. Panel responded: no copays for preventive drugs.

Mr. Colmers asked about priorities. What in the federally-qualified should we take out if we are above the 12% figure in the statute? The panel felt that preventive services will lower the premiums.

Ms. Seabolt asked that smoking cessation programs should not be overlooked.

Mr. Dan Clements
Board of Resolve of MD

Mr. Clements asked what is more important than one's family. Recommended infertility services be covered, including in vitro fertilization, because not doing so could result in stopping scientific research, which has already yielding cheaper alternatives.

The costs of such services are \$.10/month per policy. To cover every service, it only increases costs \$1.25/month.

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Last year there were only 275 adoptions, out of the 45,000 couples with infertility.

Mr. Jeffein asked how effective in vitro services are? Mr. Clements replied that it is as effective as nature, in terms of getting pregnant. Only 1% of infertile couples use it. GBMC is the best facility.

Mr. Jim Guest
Ms. Roseann Wisman
Planned Parenthood

Planned Parenthood has 11 sites in MD. They both listed seven recommendations:

- 1) Coverage of routine exams with copay.
- 2) Lower contraceptive drug costs.
- 3) Include pregnancy-related care, including abortion.
- 4) Infertility services.
- 5) Mammograms.
- 6) Reimbursement for Nurse Practicioners.
- 7) Direct Access, to allow for patients to go out of plan.

Thirteen out of 15 insurance companies cover abortion. Most contraceptive drugs are covered, but we want choice since the type used is very personal.

Tests for breast cancer, STD's save dollars.

Ms. Ellen Miller
Creative Benefit Services

She is a small business owner. Recommends:

- 1) Cover infertility services.

It is not the employer's job to talk to secretaries about family planning. Right now, there is no help/counseling available.

Ms. Lucille Coleman
Ms. Priscilla Hart
Episcopal Diocese of MD

Religious Coalition for Abortion Rights. We believe women are intelligent enough to make own decisions.

Recommend:

- 1) Family Planning and health services.
- 2) AIDS, STD services covered.

We provide family planning services. Recommend:

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Ms. Susan Armstrong
Ms. Pat Paluzzi
Nurse Midwives

- 1) Retain preventive care services.
 - 2) Include abortion.
 - 3) Equal reimbursement for services provided.
- Mr. Colmers said that HCACC will address the payment system.

Ms. Sally Gold
Lawyer

Small Business owner with four employees.
Recommends:

- 1) Gynecological exams.
- 2) family planning, abortions.
- 3) Eliminate pre-existing conditions.

Mr. Barbera replied that the statute will make discrimination on the basis of a pre-existing condition illegal.

Mr. Kevin Appleby
MD Catholic Conference

Represent 8 Hospitals and Nursing Homes, helping over 800,000 Marylanders.

Preventive care services are important, like WIC program. Child immunizations should be without copay.

No position on parity between mental health and physical health.

Family planning should not focus on artificial birth control. There should be natural family planning. Do not include abortion. 57% of abortions were from repeat abortions.

Ms. Rebecca Richards
YWCA

300 employees, 90% are women. 50% of cases which exceeded their insurance stop-loss policy were OB/GYN related. Time for equity in women's health is now. Breast health awareness is crucial.

We support abortion rights from a faith perspective.

Gynecologist by training. Dr. Moy supports the testimony by Nurse midwives in providing services.

DHMH program is for 70,000 patients a year. Problem is with teens, who account for 1/3 of all unintended pregnancies.

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Dr. Russell Moy
Director, Maternal Health and
Family Planning, DHMH

Are these services cost effective? Yes. \$4.40 savings for every \$1 spent.

Dr. Lamm asked why there was no care for these people? Dr. Moy replied that practitioners view reimbursement rates as too low.

Ms. Paik asked in the 2nd section of written testimony, where did the statistics come from? Dr. Moy said the references are listed. Most came from the Institute of Medicine.

Mr. Hillier noted there was no mention of abortion. Dr. Moy said that Title X doesn't see abortion as proper.

Ms. Griffin asked if providers can bring it up in conversation? Dr. Moy said nobody knows what really happens when a patient is with a physician.

Ms. Karen Blood
Scorpion Systems

Wanted to offer real world perspective. She owns a small business and, through personal experience, saw premiums increase. Once breast cancer was detected, even though it was benign, rates increased.

Dr. Lamm asked how much more it cost? Ms. Blood said it was built into her costs.

Ms. Griffin asked how much she could have saved? She replied \$25/month/employee.

Mr. Colmers said that Foster Higgins could find out. He asked if she has ever been cancelled? No, but options for movement are limited.

Dr. Barbara Hanley
MD Nurses Association
Mr. John Connelly
Ms. Marjorie Koehler

All three panelists asked for parity in reimbursement for services rendered. They recommended:

- 1) Advanced practice nurses should be gatekeepers.
- 2) Professionals reimbursed at same levels for services.
- 3) Remove barriers for non-physician providers.

2.1 Million nurses. 100,000 Advanced Nurses. 25,000 Nurse Practitioners.

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Cost savings since hospital days reduced 1/3 when nurses are involved.

Mr. Barbera asked why nurses are not gatekeepers currently? There are financial barriers, political ones.

Mr. Jeffein asked if nurses are independently reimbursed? Yes, under Medicare and Medicaid.

Mr. Barbera asked if they have received public recognition for services, or considered working for HMOs? There are pilot projects.

Ms. Paik asked what paranatal care was? Care before, after and during birth.

Mr. Hillier asked if they thought of integrating services in academic hospitals? The panelists agreed they could.

Mr. Barbera said it would be dangerous for the Task Force to engage in Social Engineering. He encouraged the panelists to come up with recommendations that fit.

Ms. Koehler recommended:

- 1) Services fully-reimbursed at rate for physicians.
- 2) Support screening tests, breast exams, etc.
- 3) We can provide health education, prevention.

Mr. Connelly recommended:

- 1) Utilize our cost-effectiveness, at 20-30%.
- 2) Payment based on services, not on providers.
- 3) Don't discriminate.

Mr. Barbera asked if RBRVS solves problems? We are talking about access. We bill for 20-30% less than our colleagues.

Mr. Colmers asked what would happen if reimbursement levels were equal? They would still cost less, since Nurse Anesthetist training is only \$11,000.

Mr. Hillier asked about hospitals and exclusion of services. CRNA's are paid by salary.

Mr. Jeffein asked if patients know about who provides services? No, about 6.5% have anesthetists provide services.

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Ms. Suzie Fowler
MD Speech, Language,
Hearing Assoc.

800 Audiologists. 17% of population with speech disorder. CNA insurance costs only \$.75 per policy. With a 30 visit limit, it is only \$.35 per policy.

Mr. Jim McDonald
President, MD Academy of
Audiology

Recommends:

- 1) Direct referral, so patient can see audiologist before gatekeeper.

Currently, office staff take tests and are not qualified to read results. Consequently, patient pays for physician visit, then specialist visit, then referral to audiologist.

Mr. Barbera asked if Clinton took recommendation? We don't know.

Mr. Hillier said that direct referral seems to go against reform wave, where a gatekeeper would manage services. The panel replied, Henry Ford Study says it is cheaper.

Ms. Griffin asked if most people wouldn't know about service? Yes, it is our fault.

Ms. Colleen Pierce
Ms. Phyllis Fatzinger
MD Dietetics Assoc.

Our program saves money. Less than 1/3 physicians discuss diet, yet it is diet which accounts for high costs in health care.

Recommend:

- 1) Reimburse diatetics.

Costs now save money in hospitalization bills. Each diabetes patient could save \$1,000's of dollars because of early intervention.

Mr. Hiller asked if the insurance carriers looked into their cost savings? We are covered on a case-by-case basis. Not on standard benefit plans. HMOs have us on staff.

Mr. Joel Kruh
Dr. Reeve Askew
Dr. Howard Balduc
Chiropractors

Recommendations:

- 1) Fully-Fund Chiropractors.
- 2) Hospital privileges.
- 3) Take steps to include our services.

Canada conducted a study which found the following:

- 1) Lower back pain leads to excessive costs.
- 2) Leading cause of disability and most expensive part of workman's comp.
- 3) Chiro. more effective than other alternative providers.
- 4) Lower costs more effective than medical management.
- 5) Reduction in hospitalization rates.
- 6) Patient satisfaction is high.
- 7) Even with out-of-pocket costs, practices are increasing.

Mr. Jack Benigni
Respiratory Care

1,500 Practicioners in MD.

Recommendations:

- 1) Setup structure for reimbursement.
- 2) Follow-up visits.
- 3) Fully fund services.
- 4) Look at studies which find savings.

We reduce rehospitalizations by 80%.

Dr. Zachary Chatter
Podiatric Medical Assoc.

Foot care accounts for 3.6% of all health care costs.
\$1.2 billion are for amputations. Regular foot visits
reduce amputations by 50%.

Hopkins Study:

- 1) Podiatrists are less expensive.
- 2) No significant increase in cost if included in plan.

Mr. Hillier asked if Hopkins made changes due to this study? There are a couple of podiatrists on staff at Hopkins.

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Mr. Casey Hughes
Psychological Assoc.

Recommendations:

- 1) If you are licensed, you should be reimbursed.
- 2) Freedom-of-Choice.
- 3) No Discrimination.

Mr. Colmers challenged Mr. Hughes to be creative and asked about recommendations on parity? Yes. It is in packet.

Mr. Dan Doherty
Oral Surgeons

Recommendations:

- 1) Cover Trauma cases.
- 2) No Discrimination.
- 3) Birth defects, developmental problems should be covered.

Under JCAHO, oral surgeons cannot admit patients. We can treat facial trauma.

We have a 48-month minimum residency program.

Ms. Carol Kari
Acupuncture Society

200,000 patients per year. 300 licensed practitioners in state. Average cost per visit is \$50-65. Blues reimburse us at 80-100%.

68% patients covered by insurance. There are studies on our cost-effectiveness.

Federal level is considering a 50/50 cost-sharing. That is our recommendation.

Ms. Beth Biernan
Social Workers

50% are currently employed by staff hospitals. We conduct:

- 1) Discharge planning.
- 2) Well-child care.
- 3) School-based clinics.

We are a low-tech service. There is a national demonstration project that follows a Triad after the birth of a child.

We also teach preventive services.

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Ms. Donna Wells spoke of the importance of EAP's which employ social workers.

The meeting adjourned at 6:40pm.

DRAFT

6th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE
SEPTEMBER 23, 1993

Co-Chairman Tom Barbera called the meeting to order at 4:15 p.m. In attendance were: Co-Chairman Don Hillier, Linda Breland, Arthur Ebersberger, Rosalind Griffin, and Dennis Murray.

Commission staff was represented by: John Colmers, Ann Rasenberger, Elizabeth Sammis, Tom Murray, and Alan Hoffman.

Mr. Barbera announced that this meeting was a work session to select various benefits to be priced out by Foster-Higgins. He proposed that the members first take a few moments to review the draft minutes of the previous two meetings where public testimony had been received on various benefits, second review a list of possible benefits and decide which are in and out, third review the benefits to be included and discuss any limitations or variations, and fourth discuss co-payments, deductibles, coinsurance, out-of-pocket limits, and lifetime maximums. This procedural suggestion was agreed to.

ITEM I

The Task Force took a few minutes to read and review the minutes from the previous two public meetings.

ITEM II

The Task Force members reviewed a list of services prepared by staff. The list was compiled from health benefit plans collected by the staff, Maryland's mandated benefits, President Clinton's proposed benefit plan, and public testimony. Dr. Hal Cohen suggested that nutritional services be added to the list as a separate category and the members agreed.

The Task Force consensually agreed to begin with the following health services:

Hospital Services

Outpatient Care

Emergency Services

Preventive Services

Home Health Care

Hospice Care

Durable Medical Equipment
Outpatient Laboratory and Diagnostic Services
Pregnancy/Maternity
Speech, Occupational, and Physical Therapy
Skilled Nursing Facility
Infertility
Family Planning
Mental Health/Substance Abuse
Prescription Drugs
Nutritional Services

The Task Force agreed not to separately price the following:

In vitro fertilization
Oral Surgery
Alzheimer's
Blood Products
Catastrophic Health Coverage
Cleft Lip and Palate
Second Opinion
Diagnostic or Surgical Procedures involving Bones of the
Joints of the Face, Neck, or Head
Cardiac and Pulmonary Rehabilitation

ITEM III

The Task Force members then returned to each of the benefits and began to discuss the variations and limitations to be placed on each for Foster-Higgins to follow in pricing out the benefits.

The Task Force agreed to have the standard benefit plan proposed by President Clinton costed out by Foster-Higgins for Maryland's small group market.

In addition the Task Force agreed to the following benefit variations and limitations:

I. Hospitalization

- (A) 365 days
- (B) 30 days

II. Mental Health and Substance Abuse: Assume a managed care environment for all variations described. Foster-Higgins will specify what they assumed and meant by managed care.

- (A) 30 days inpatient per year
- (B) President Clinton's proposed benefit
- (C) Outpatient Visits: Foster-Higgins will look at a range of visits and co-pays/coinsurance amounts to determine the maximum number of visits that could be included with the least out-of-pocket expense
- (D) Full parity meaning full parity with hospital services and outpatient care and including non-discrimination for prescription drugs
- (E) Maryland's current mandate
- (F) Foster-Higgins will provide a separate figure for how much a non-managed care environment would cost

III. Preventive Services (including family planning)

- (A) President Clinton's proposed benefit
- (B) U.S. Preventive Services Task Force package
- (C) Maryland's mandate for child wellness and screening mammography

IV. Home Health Care

- (A) Same as Medicare
- (B) 40 visits

V. Hospice

- (A) Same as Medicare
- (B) No benefit

VI. Durable Medical Equipment

- (A) President Clinton's proposed benefit
- (B) No benefit

VII. Outpatient Laboratory and Diagnostic Services: Vary benefit by co-payments

VIII. Pregnancy/Maternity

- (A) Included
- (B) Excluded

IX. Speech, Occupation, and Physical Therapy

- (A) President Clinton's proposed benefit
- (B) Excluded

X. Skilled Nursing Facility

- (A) President Clinton's proposed benefit

XI. Infertility: no in vitro fertilization

- (A) \$5,000/calendar year for a maximum of 5 years

XII. Prescription Drugs

- (A) Generic Substitution unless unavailable
- (B) Generic Substitution unless unavailable and no birth control pills
- (C) Co-payments and Deductible options
 - (1) Co-pays and deductibles in President Clinton's proposed plan
 - (2) 20 percent coinsurance
 - (3) For all plan types, \$250 deductible and 20 percent coinsurance
 - (4) \$5 co-pay for all plans

XIII. Nutritional Services

- (A) Maryland's mandate

ITEM IV

The Task Force members then discussed co-payments, deductibles, coinsurance, out-of-pocket maximums and lifetime maximums for different plans.

I. Low and High Cost-Sharing identified in President Clinton's proposed benefit plan

II. Indemnity Plans

80/20 coinsurance

\$250/\$500 deductible

\$2500/\$5000 out-of-pocket limit

\$250,000 and \$1 million lifetime maximum

III. PPO

In-Network: 90/10 coinsurance

Out-of-Network: 70/30 coinsurance

Other cost-sharing same as indemnity plans

IV. HMOs

\$10 co-pay per office visit

V. POS

The Task Force members were unclear on the types of POS plans, how POS plans by indemnity carriers compare to HMO carriers. Cost-sharing specifications were deferred.

**7th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

September 30, 1993 | Cambridge, MD

Co-Chairman Tom Barbera called the meeting to order at 5:00 p.m.

In attendance were: Co-Chairs Don Hillier and Tom Barbera; and members Linda Breland, Arthur Ebersberger, Rosalind Griffin, Michael Merson, and J. Dennis Murray.

Commission staff was represented by: John Colmers, Elizabeth Sammis, Ann Rasenberger, and Alan Hoffman.

ITEM I

Opening Remarks

Co-Chairman Hillier welcomed the audience and announced the format for the hearing. He also read the charge of the Task Force to the audience.

ITEM II

Approval of Minutes of September 9th, 17th, & 23rd

Mr. Ebersberger motioned to approve the minutes of September 9, 17, 23, 1993 with the following correction to the September 17th minutes: p.11 replace "oral surgeons cannot admit patients" to "oral surgeons can admit patients." The motion was second by Mr. Murray and passed by unanimous consent.

ITEM III

Public Testimony

A. Lewis Kadushin, Ph.D.

Mr. Kadushin stated he was a Salisbury psychologist. He has been in Salisbury since 1972 and was one of the first psychologists to practice in the area. He has worked for EAPs doing brief interventions. He said a variety of interventions are successful at keeping people on the job and productive. He asked the Task Force and Commission for sufficient and appropriate compensation.

B. Adrianne Kadushin, RN, MA, CS-P

Ms. Kadushin stated she was a psych-nurse and a LaMans instructor. She believes the need for mental health services cannot be overstated. The Eastern Shore is an under-served area. She does not understand why mental health services are reimbursed less than physical services. She recommends providing generous outpatient services which she views as cost effective. Ms. Kadushin complained about lack of timely publicity for this meeting.

C. Marilyn Stone

Ms. Stone is Director of Caroline County Mental Health Clinic. She also commented about the lack of publicity for the meeting. She wished there was more consumers here to testify. She asked for more services for children, especially in the school setting. She stated that in rural areas transportation is always a problem. She believes early prevention is the only way to avoid large mental health expenses on adults.

Co-Chairman Hillier said the Task Force worked with the Chamber of Commerce to get small businesses and consumers to attend.

D. Debra Lund

Ms. Lund is testifying for the Maryland Association of Cardiovascular and Pulmonary Rehabilitation. Cardiovascular and pulmonary rehabilitation is a multi-disciplinary field. She stated the cardiovascular and pulmonary rehabilitation is cost effective. It reduces length of hospital stays and increases the quality of life.

Ms. Breland asked in what setting is cardiovascular and pulmonary rehabilitation performed. Ms. Lund stated that the rehab occurs on an outpatient basis, and that in Maryland the majority occurs in hospital outpatient departments. Rehabilitation is normally prescribed for about 1 hour, 3 days a week. Total cost typically ranges between \$1,500 and \$2,000.

Co-Chairman Hillier asked if third party payors cover cardiovascular and pulmonary rehabilitation. Ms. Lund responded that Medicare and the majority of commercial insurers cover it. Blue Cross/Blue Shield of Maryland requires a rider which is only available for large companies.

Co-Chairman Barbera announced that the Task Force has asked Foster Higgins not to include this service when pricing out benefits. Mr. Merson said this was not clear from reading the minutes of September 23, 1993. Co-Chairman Barbera asked the staff to make appropriate changes to the minutes of September 23, 1993.

E. Dr. Margaret Renzetti

Dr. Renzetti is a chiropractor from Cambridge and is here representing the Maryland Chiropractic Association. She stated that manipulation is an ancient art from Greece. Modern chiropractic care has been in this country for about 100 years and has stood the test of time. Dr. Renzetti said chiropractors are the third largest provider group. She stated that the American Medical Association systematically tried to stamp out chiropractors. She then read part of the federal court decision in favor of chiropractors.

Dr. Renzetti does not like the monopoly physicians have on gate-keeping. She stated that no other group has the type of training in manipulation chiropractors have. She believes that chiropractic services cannot be covered under another umbrella.

She stated that many chiropractors are in rural areas and can relieve the doctor shortage in these areas. The efficacy of chiropractic services has been proven in workers' compensation studies from California and Florida, and a Rand Corporation study. A Canadian Study, Manga Report, recommended that lower back care be shifted from medical to chiropractic care.

Mr. Merson asked if third parties cover chiropractic care. Dr. Renzetti responded that it varies from carrier to carrier. Blue Cross/Blue Shield cover it at various rates. Gatekeeper systems, HMOs such as MD IPA, claim they offer chiropractic care but they have so much red tape they frustrate many patients. In such systems usually a neurologist has to approve the care. They often do not have the knowledge to be a good gatekeeper.

Dr. Renzetti stated that chiropractors take care of Medicare and Medicaid patients. Medicare coverage was limited to 12 sessions. Before receiving chiropractic care an x-ray was required every year. In the past, only a medical doctor could be reimbursed for the x-ray. Dr. Renzetti believes this stipulation might have been eliminated. On the subject of Medicaid patients, Dr. Renzetti said she could not speak for the profession as a whole, but that services are often done on a cash basis or the chiropractor is never reimbursed.

Co-Chairman Hillier asked Dr. Renzetti if the standard benefit plan uses a gatekeeper was she worried chiropractors would not get referrals. Dr. Renzetti replied that the communications between physicians and chiropractors were not good, and that referrals do not flow smoothly.

Dr. Renzetti stated she wanted consumers to have a choice to choose their own physician and have chiropractic care accessible to consumers.

Mr. Murray commended chiropractors on the amount of information they have sent to the Task Force.

F. Dr. Curry

Dr. Curry is a chiropractor from Salisbury and is here representing the Maryland Chiropractic Association. He is a professional in a muscular-skeleton pain clinic. He works side by side with a Medical Doctor (MD) in neurology, an Osteopathic Doctor (DO), a physical therapist, and allied health professionals.

He stated that to his understanding the Task Force intended to make the standard benefit plan service but not provider specific. This approach, according to Dr. Curry, would leave chiropractic care unclear of its future position. Chiropractors have enjoyed a primary care status in Maryland for 72 years.

Dr. Curry listed three major points favoring chiropractic care:

- 1) Uniqueness of care - Chiropractors look at joints and muscles. They treat patients manually. Furthermore chiropractic care is more cost effective than standard medical care. Chiropractors have the skills needed to make a diagnosis and to treat. Usually a neurologist needs to diagnosis and a physical therapist needs to treat in standard medical care.
- 2) Increase market forces - Chiropractors bring competition into the marketplace.
- 3) Public Demand - Chiropractors survived due to grass root support from their patients. In the 1960s patients were willing to pay out-of-pocket for chiropractic care until insurance companies began to cover it. Chiropractic care is facing new threats and problems, this time from managed care.

Dr. Curry believes that an MD gatekeeper is unnecessary, inefficient, and increases biases. He wants provider specific language in the standard benefit plan.

Co-Chairman Hillier stated that the plan discussed last week was service oriented. Anyone who can perform the services is covered. He asked Dr. Curry if this worried him? Dr. Curry responded that in the past they have had problems with managed care plans.

Mr. Ebersberger asked Co-Chairman Hillier if we were not going to dictate to carriers who must provide the service. Co-Chairman Hillier responded that this was correct.

G. Dr. John Ryan

Dr. Ryan is a Health Officer from the Talbot County Health Department and is a member of the American Academy of Pediatricians. Dr. Ryan stated that women's health and family planning, maternal health, and substance abuse services are all cost effective and give high rates of return. He specifically mentioned pap smears, mammography, and contraception.

He wants to remove the economic barriers to prenatal care. He also wants discharges for uncomplicated births to be at 48 hours. For substance abuse, Dr Ryan wants residential treatment to be covered under the right circumstances. He believes smoking cessation should be covered because 40% of all cancer deaths in Maryland can be contributed to smoking according to the DHMH.

Being a health officer in a rural area, Dr. Ryan recommendation is that benefits need to:

- be easy to use;
- require the least paper work; and
- maximizes the availability of resources.

Ms. Griffin asked Dr. Ryan to recommend a specific split between inpatient and outpatient services for mental health. Dr. Ryan replied that he had no expert knowledge in the area, but the movement was towards more outpatient services.

Co-Chairman Hillier asked Dr. Ryan if he believed nicotine patched were medically necessary. Dr. Ryan replied yes. Ms. Griffin asked if he would require a behavior modification program. Dr. Ryan replied it would be ideal if they went to a group.

F. Fran Tracy Mumford

Ms. Mumford is a member of the Maryland Commission for Women and the Wicomico County Commission for Women. She stated she represents both consumers and the businesses providing coverage. She also wishes to speak in support of services for women. She is interested in adequate health care coverage for all women.

Ms. Mumford stated that access to services is essential. One in six women are not covered by a plan. She also believes that preventative measures must be included. They are economical because they prevent diseases from occurring. Gynecological services including pelvic exams, pap smears, and breast exams, and mammograms are critical. Maryland has a high cancer rate, especially breast cancer which is in epidemic proportions. If preventative measures are not covered, people will only seek treatment when they have a problems, and the cost effectiveness of preventative services will be lost.

She believes family counseling and prenatal services must be included. Up-front services will prevent these "million dollar babies" being born to mothers who had no prenatal care.

Co-Chairman Hillier pointed out that the Task Force is designing a plan for small employers and that the Task Force will not be able to solve all of society's problems. For example, this plan will not effect women who are not in the work force.

G. Delpine Slaughter

Ms. Slaughter was a victim of a house fire four years ago. She lost two children in the fire and had to be flown to Francis Scott Key Medical Center in Baltimore because there is no burn center on the Eastern Shore. After her initial stay, she had to have two additional surgical procedures. She had the procedures done under the assumption that her Medical Assistance card would cover her bills. Since she no longer had living children, she was no longer qualified for Medicaid under federal rules. She is currently being sued by Francis Scott Key and is considerably distressed.

She told the Task Force she is having trouble getting insurance. She wants to make sure services for burn survivors is included in any package.

Mr. Ebersberger stated that after January 1995 preexisting conditions will be eliminated from the small employer market and that this will be a big help to people such as herself.

Executive Director Colmers stated that when the state only program was eliminated hospitals got \$70 million to cover this care. He suggested Ms. Slaughter talk with Mr. Wigglesworth of the Maryland Hospital Association, who was in the audience, after the meeting.

H. George Barnett

Mr. Barnett stated he was primarily here as a consumer who lives in Cambridge. He is a state employee who is involved with personnel issues. He asked the Task Force if he was correct in believing the State could come under the plan. Executive Director Colmers said that self funded plans can join the community rated pool.

Mr. Barnett stated that in the last five years he has seen an increase in the number of contractual employees and a decrease in the number of merit system employees. Contract employees get none of the benefits merit employees receive. He felt it ironic that State agencies which provide care or access to care have a subclass of employees who are not covered by health insurance.

ITEM IV

Presentation on P.O.S. Products

Presenters:

- Marilyn Mosby, Blue Cross/Blue Shield of MD
- Dale Sommers, Blue Cross/Blue Shield of MD
- Linda Hacker, CIGNA Mid-Atlantic Health Plan

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- Jayn A. Osler, Prudential Insurance Company of America,
Mid-Atlantic Group Operations
- David S. Iannucci, Prudential Insurance Company of America,
Mid-Atlantic Group Operations

Co-Chairman Hillier announced that there were several people from the industry present to give a presentation on Point of Service Plans. When discussing cost sharing at the last Task Force meeting it became clear that members could not delineate a specific definition of a POS plan.

Executive Director Colmers told the panel the Task Force was interested in receiving advice on how to structure contract language.

Mr. Sommers distributed a handout highlighting some of the similarities and differences between an indemnity and an HMO point-of-service product. All POS plans have three key features: 1) primary care physicians (PCP) are responsible for the management of care in all types of POS plans; 2) PCPs can be reimbursed on a capitated (typical of HMO based plans) or a fee for service basis (typical of indemnity based plans); and 3) an out-of-network option.

There is a nominal co-payment for care received in a network ranging from \$5 to \$10. For out of network care there is a larger out of pocket cost which can include a deductible and co-insurance.

After much discussion among the Task Force members and the panel, it became clear that there was no simple definition of a POS plan. Such plans could be offered from a HMO base with an additional insurance contract or self-insurance rider, or they could be developed on an insurance license by an indemnity provider. The panel also pointed out that there were currently many regulatory barriers to developing a POS plan.

Executive Director Colmers told the panel that the Task Force is interested in developing a uniform plan. There will be different cost-sharing features as the plan setting changes. He stated the goal was to limit ambiguity and make it easier for businesses to compare plans on cost.

Co-Chairman Barbera asked the carriers if they were offering POS plans in the small group market. Mr. Sommers responded that POS plans were new to this market but extremely popular.

Deputy Director Sammis asked if it would be legitimate to view the cost sharing of a POS plan as being similar to a HMO for in-network services and similar to a PPO for out-of-network services. Ms. Hacker responded affirmatively but added that the cost sharing for a POS plan (typically 70% / 30%) was higher than a PPO because the plans are interested in attracting people who will primarily use the in-network options.

Both Mr. Iannucci and Mr. Merson stressed the growing popularity of POS plans. Mr. Merson added that the market place is in a period of rapid innovation. Mr. Merson then explained the concept of the triple option POS plan. It is this type of plan more and more consumers are demanding.

The Task Force agreed that they did not want the standard benefit package to stifle innovation. Co-Chairman Barbera and Mr. Merson stressed to the panel the importance of the industry working with the Task Force. It was concluded that the proper industry personnel were not present to discuss the finer details of POS plans. A meeting was set for Friday, October 8, 1993 at 12:00 p.m. at 4201 Patterson Ave. for health plan executive and the Task Force to continue the POS discussion. The meeting is open to the public and a room will be announced.

ITEM V

Further Public Testimony & Other Business

Co-Chairman Barbera offered any late-comers an opportunity to testify.

A. Dr. James Kelly

Dr. Kelly is a physician from Easton. He believes the Task Force needs to ensure that the contracts being developed are written in clear layman language. People are purchasing plans but are not aware of what services they are purchasing. He said that plans offer different benefits under the guise of the same contract language. For example, the contract might offer psychological benefits for all approved services. In reality, however, it is hard to get approval in many plans.

B. Jack Farego

Mr. Farego is an executive of Chesapeake Health Plan. He believes it is important for people to understand their plans. He told the Task Force that many people at the meeting commented to him that if the Task Force members had trouble understanding some of the issues, what chance does the public have in understanding them.

Deputy Director Sammis thanked Mr. Farego for publicizing the meeting on the Eastern Shore.

The meeting adjourned at 8:30 p.m.

**8th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

October 7, 1993 | Cumberland, MD

Co-Chairman Tom Barbera called the meeting to order at 6:00 p.m.

In attendance were: Co-Chairmans Thomas Barbera and Don Hillier; and members Linda Breland, Arthur Ebersberger, Rosalind Griffin, Gerald Jeffein, Dr. William Lamm, and J. Dennis Murray.

Commission staff present: Executive Director John Colmers, Deputy Director Elizabeth Sammis, and Alan Hoffman.

ITEM I

Opening Remarks

Co-Chairman Barbera announced that he was pleased to have such a good turn out for tonight's meeting. He said the Task Force was charged by the Governor with developing a standard benefit package to be offered to small businesses. The Task Force's assignment tonight is to hear testimony from anyone wanting to talk about the standard benefit package.

Dr. Lamm thanked everyone for attending, especially his fellow Task Force members who had to drive some distance. Dr. Lamm said Delegate Casper R. Taylor, Jr. sends his regards, but unfortunately cannot attend due to a meeting in Annapolis.

ITEM II

Public Testimony

A. Dr. Robert Brodell

Dr. Brodell is a pediatrician in Cumberland, was a member of the Governor's Commission on Infant Mortality, and a member of the Maryland Chapter of the American Academy of Pediatricians. He wants flexible mental health benefits, childwellness services, and prenatal and preventive care in the benefit package.

Maryland has a high infant mortality rate, even though a wealthy state. Much of the infant prematurity that is the primary factor in the high mortality rate is related to access to health care. Children born premature cost the system much money. Preventative child care is an area of medicine that is going under a revolution. Dr. Brodell feels that Maryland can be a leader in this movement for change.

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Dr. Brodell heard that a past discussion of the Task Force centered on not covering blood products. He believes if the SBPTF eliminates blood products, they are overlooking the child who has hemophilia.

Dr. Brodell believes that pediatricians, internist, general practitioners, and family practitioners should be designated as primary providers.

Dr. Brodell believes malpractice reform is essential in order to ensure an adequate supply of medical personnel, especially in rural area. He stated that 10% of the population seen by the medical system in Allegheny County is involved in malpractice suits. Upon questioning from Mr. Colmers, Dr. Brodell said the 10% figure was merely observational.

Dr. Brodell also advocated for the inclusion of medical devices such as hearing aids and eye glasses. He believes there should be no co-pays or deductibles for aids that help handicapped children function in society.

B. Dr. Philip Lavine

Dr. Lavine has been a practicing psychiatrist in the community since 1980. He was Director for Mental Health for Western Maryland in the late 1980's. He stated he does not envy the Task Force's duties.

He supports Dr. Brodell's position of more mental health services for children. The typical 50% co-pay for outpatient services prevents many children from getting appropriate care. Currently, much of the cost of mental health services is inpatient care. This is a key factor in the lack of adequate outpatient reimbursement. Many times a person does not receive treatment until a crisis occurs which requires inpatient care. Dr. Lavine stated he has seen a gradual whittling away of mental health outpatient benefits.

Co-Chairman Barbera asked what would be the exact number of inpatient days you would recommend the plan cover, remembering we have to balance it with outpatient visits in order to stay within our cost parameters. Dr. Lavine responded that the average stay was 10 to 12 days per admission in a psych-unit. However, schizophrenia takes 5 to 6 weeks to resolve. The mental health community, according to Dr. Lavine, has gotten use to treating patients with inadequate inpatient stays. He would recommend shorter inpatient coverage if this would fund more outpatient visits.

Dr. Lavine said 100% coverage of outpatient visits would be ideal. He believes there should be a cap on coverage, but it should be way beyond the typical 10 to 12 visits offered by some insurance companies. A CHAMPUS study showed that increasing mental health outpatient coverage to 80% reduce inpatient costs.

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Dr. Lamm asked what would your choice be between decreasing copays and deductibles versus decreasing the number of outpatient visits. Dr. Lavine said he would rather see days limited but with a lower copay/coinsurance. He stated most people do not like going to psychotherapy. People do not come for therapy until they are at wits end. Seriously mental ill people require long-term care. Most get this through the public sector at no cost. There is a whole group of people with more acute illness that do not need long-term care. They need care only for months.

Co-Chairman Barbera asked Dr. Lavine about combining mental health and substance abuse benefits. Dr. Lavine replied that substance abuse is more prevalent than mental illness, with 18% of the population having substance abuse problems in any given 6 month period. He also stated that there is a lot of co-morbidity between the two.

Dr. Lavine then talked about the efficacy of mental health services. Most treatments have been document with efficacy rates between 60% to 80%. This is tops in medicine. Angioplasty is covered by insurers and it has substantially less efficacy.

In response to a question by Mr. Jeffein, Dr. Lavine stated that children should have broader benefits than adults. Treating mental illness in children will prevent even worse complications in the future.

C. Roger Stenson

Roger Stenson is the Executive Director of Maryland Right to Life, Inc. He stated that according to polls most people find the killing of human fetus morally repugnant. People should not be required to pay for other people's abortions. Abortions should not be treated like other medical procedures. Mr. Stenson read a quote from the United States Supreme Court in Harris v. McRae (1980) that stated, "Abortion is inherently different from other medical procedures, because no other procedure involves the purposeful termination of a potential life."

Mr. Stenson argued abortion should not be a benefit in the standard benefit plan. It should be covered by a rider or through supplemental insurance.

Ms. Griffin asked if he had any evidence that abortion coverage increases costs. Mr. Stenson replied that he had no evidence. He said Mutual of Omaha, the largest insurer for individuals, does not offer abortion services because of its expense.

D. Jamie Dixon

Ms. Dixon is a manager of the Cardiac and Pulmonary Rehabilitation Center at Frederick Memorial Hospital. She is here as a representative of the Maryland Association of

Cardiovascular and Pulmonary Rehabilitation.

Ms. Dixon wants cardiac and pulmonary rehabilitation covered in the standard benefit plan. Cardiac and pulmonary rehabilitation is a process which the person with cardiovascular disease is restored to and maintained at his or her optimal physiological, social, vocation and emotional status. It is a multidisciplinary approach which involves exercise, emotional support, education, risk factor adjustment, etc.

Hospital stays are too short for educational programs to take hold, according to Ms. Dixon. This is the reason why outpatient cardiac & pulmonary rehabilitation is so important. It is cost effective because it reduces hospitalization and the use of medical resources.

E. Dr. Fred Miltenberger

Dr. Miltenberger is a physician practicing in Cumberland. Dr. Miltenberger stated that fee-for-service reimbursement is still a valid way to practice medicine. He said, "The Commission can modify it, place caps on it, collect data on it, but please do not kill it." Relationship between physician and patient under the fee-for-service system will never be matched with other systems.

For example, Dr. Miltenberger stated he does gastroscopes and surgeries. One of the largest insurers in the area requires a barium first before a gastroscopy. A barium is cheaper but not as good. This procedure often subjects a patient to two tests instead of one. He does not understand why he cannot do a gastroscopy initially and get to the bottom of a patient's problem right away.

Dr. Miltenberger believes if we are going to introduce these novel cost saving measures, we need to educate the public. He believes liability reform is a necessary part of House Bill 1359. He said more reform was initially introduced but unfortunately such measures as a cap on wrongful death were removed. He would like to see Maryland enact the liability reforms adopted by California ten years ago. He believes managed care hampers the quality of care and increases the threat of malpractice. Under managed care physicians are doing without many tests and tools fee-for-service physicians use.

F. Dr. Heather Pierce

Dr. Pierce is a local endocrinologist. She believes Dr. Miltenberger's comments on managed care are correct. A health plan in the area requires people to go through a primary care physician (PCP) before they see her. She has had problems with the lab the plan forces her to use. She is also upset that the lab results will only be sent to the PCP and not to her office.

Dr. Pierce is also worried about the growth of capitation and the pressure on physicians to see more patients.

Dr. Pierce said she treats many diabetics. Currently education and dietetic services are not usually covered. Preventative care is extremely important for diabetics. Diabetics should be seen by their physician 3 or 4 times a year. They need encouragement and/or a kick to stay on their regiment. Diabetics have many costly complications. Dr. Pierce has seen diabetic complications actually be reversed by better management.

She does not understand why the cost of products, such as monitoring strips, keep increasing. Some plans cover strips, but many plans do not. She stressed that the cost of complications is much higher than the cost of supplies.

G. Dr. Audie Klinger

Dr. Klinger is a chiropractor representing the Maryland Chiropractic Association and the Maryland Board of Chiropractic Examiners. He also is representing dually licensed chiropractors, those that can do chiropractic care and physical therapy.

Chiropractors have many problems under managed care systems. According to Dr. Klinger, the HMO industry in Maryland refuses to use chiropractic services. He stated that Cigna, even with a PCP referral, still refuses to approve chiropractic care.

H. Dr. Jack Murray

Dr. Murray is a chiropractor who has been practicing in Cumberland for 42 years. He wants chiropractic services mentioned specifically in the standard benefit plan.

When he first started there was little insurance coverage for chiropractic care. After a long struggle, carriers began to see it as cost effective care and the profession began to get coverage. It took Medicare eight years from its inception to cover chiropractic services. In 1970, Maryland enacted laws to make chiropractic care reimbursable and hence widely available to the public.

Mr. Murray commended the chiropractors for the amount of information they supplied to the Task Force.

I. Dr. Eric Hasemeir

Dr. Hasemeir is a osteopathic physician and is President of the Maryland Association of Osteopathic Medicine. He practices in the rural area of Westernport where many of his

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patients are poor and on Medicaid.

He stressed that D.O.'s are really doctors. They can prescribe medicine, admit patients to hospitals, etc. Osteopaths represent 5% of the physicians in the United States, but represent 15% of the doctors working in rural areas.

They are different from M.D.'s (allopathic doctors) in the following way:

- philosophy of care is holistic
- can practice osteopathic manipulation
- emphasize preventative care.

Both D.O. and M.D. are licensed to practice in all 50 states. He wants the Task Force to remember physician does not just include M.D.'s. He also wants the inclusion of osteopathic manipulation in the benefit plan.

J. Dr. Jim Orth

Dr. Orth is a clinical psychologist practicing in Cumberland. He primarily serves children/adolescents and their families. He sees inadequate access because of poor insurance coverage. He often sees the premature termination of treatment or inadequate intensity of treatment.

Mr. Murray ask if he shared the view of the other doctors on lower copays but less outpatient visits. Dr. Orth stated that the balance needs to shift to better outpatient coverage.

K. Melinda Sadler

Melinda Sadler is the President of Maryland National Organization for Women (NOW). Ms. Sadler read a written statement to the Task Force.

She said, "Counseling and services for family planning, including payment for contraceptive devises drugs and devices are essential. . . Pre-natal care and post-natal care is imperative for women, all women, to remain healthy during and after pregnancy, and for the delivery of healthy babies. The cost of which is far less than neo-natal intensive care."

Ms. Sadler further stated, "The National Organization of Women believes that abortion is a civil right, and should be treated as such, with one standard applied to all women. . . Granting access to legal abortion is simply a continuation of services offered by most plans to some women today, and a continuation of reproductive freedom for all women."

"In addition, NOW, also endorses a plan that will cover fertility treatment; sexually transmitted diseases; reproductive tract cancer; coverage for adoptive children regardless of age, on the same basis as coverage of a child born into a family; disease that predominately effect women such as chronic fatigue syndrome, endometriosis, etc.; mental health services; adequate home nursing care provided to patients released from the hospital before they are able to care for themselves; elder care; and long term care for health disorder."

L. Susan Roberson

Ms. Roberson is Director of an Outpatient Substance Abuse Clinic of the Health Department of Allegheny County. She wants inclusion of substance abuse treatments in the standard benefit package. Substance abuse is a chronic and fatal disease. The price of addiction is costly to society. For example, addiction plays a role in car accidents, crime, spouse abuse, accidents in the workplace, and fetal alcohol syndrome. The local jail administrator suspects that between 60% to 80% of his inmates have a connection with substance abuse.

Treatment for substance abuse both works and is cost effective. Ms. Roberson stated the Clinic had a treatment success rate of 60% to 80%. This is a good rate especially considering that in Allegheny County many people were in treatment due to a court order.

In response to an inquiry by Mr. Murray's, Ms. Roberson answered the success rate of outpatient treatment versus inpatient treatment is about equal. In Allegheny County, according to Roberson, residential treatment is \$120 per day versus \$30 for an outpatient visit.

Ms. Roberson advocated for a full continuum of services to be covered. She stressed that it was important to match the person with the treatment. She believes the majority of clients do not need residential treatment, but the ones who do need it, have a great need for it. For example, adolescents do better in a residential program because it gets them away from their families.

In response to Co-Chairman Barbera question on coverage, Ms. Roberson responded that some plans cover residential programs but more and more plans are choosing not to cover.

**9th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

October 21, 1993

Co-Chairman Don Hillier called the meeting to order at 4:00 p.m.

In attendance were: Co-Chairmans Thomas Barbera and Don Hillier; and members Linda Breland, Rosalind Griffin, Gerald Jeffein, J. Dennis Murray, Joan Paik.

Staff Present: Executive Director John Colmers, Deputy Director Elizabeth Sammis, Hal Cohen, Ph.D. and Alan Hoffman.

ITEM I

Opening Remarks and Distribution of Minutes

Mr. Barbera announced that the Task Force will be meeting on Saturday, October 23, 1993; Thursday, October 28, 1993; and if necessary Saturday, October 30, 1993.

The meetings on Saturday, October 23rd and 30th are work sessions. Mr. Barbera told the public that the staff will make a list of all decisions made on October 23rd available on Monday, October 25th. Mr. Barbera said the Task Force was looking forward to hearing from the public on Thursday, October 28th concerning the decisions made on Saturday, October 23rd.

Mr. Barbera also announced the distribution of minutes from the 7th and 8th public meeting. He asked his fellow Task Force members to be prepared to approve them at the next meeting.

ITEM II

Public Testimony

- A. Barbara Brocato & Dr. David Davis - MD Chapter, American College of Emergency Physicians

They encouraged the adoption of the definition of emergency the legislature had passed last session. They stated that managed care organizations use the emergency room as a safety net. They supported the use of copayments for emergency room usage. They believe the copays should not be waived, even if an individual is admitted.

B. Elizabeth Hollomon - MD Hemophilia Coordinator

Ms. Hollomon stated that 400 people in Maryland are hemophiliacs. She described the complications and problems suffered by individuals with hemophilia. The National Hemophilia Foundation concluded that untreated complications can cost \$500,000 per person.

Ms. Hollomon stated hemophiliacs are a small segment of the population, but they can be impacted enormously by ill conceived regulations. She said there is also a moral obligation to protect these individuals and their family from extreme hardship.

C. Pat Landis - MD Society for Cleft Lip & Palate

Ms. Landis said that children born with cleft lip and palate have multiple problems. They do not hear well, cannot talk well, and therefore, will not do well in school. She said the surgery these children receive is necessary and not cosmetic.

Only 50 children a year are born with cleft lip and palate in Maryland. Blue Cross and Blue Shield estimated that coverage for cleft lip and palate only added \$.007 to the cost of a policy between 1982 and 1986. The treatment is cost effective because it assures that these children become fully functioning adults.

D. Mendy Nitsch - MD Society for Cleft Lip and Palate

Ms. Nitsch was born with a cleft lip and palate. She said she has personally benefited from the Maryland Cleft Lip and Palate Mandate legislation. She says adequate coverage for a variety of procedures is necessary in order not to over burden families. It does not make sense that some insurance companies cover surgery, such as bone grafts, but not the orthodontic treatment which is required afterwards.

E. James DeArmon - Hemophilia Association of the Capital Area

Mr. DeArmon said internal bleeding into joints and organs is the major problem hemophiliacs face. His son was diagnosed as having a severe factor-A deficiency. He was able to receive comprehensive service which included the most appropriate clotting factor, social work, etc. His son gets home visits which help keep the cost of hospitalization down.

Mr. DeArmon advocated for full coverage of services and products needed to treat hemophilia. He will get a written statement along with formal contract language to the Task Force next week. Mr. Barbera urged him to submit the contract language to the staff before the meeting on Saturday, October 23, 1993.

F. Rona Kramer - Kramer Enterprises

Ms. Kramer is a business women in Montgomery County. She is on various boards and just completed a term on the Montgomery County Chamber of Commerce. A large percent of owners and employees of small businesses are women. The standard benefit plan will not be purchased if it does not meet the needs of women. Primary care for most women involves a gynecological exam consisting of a pap smear, STD screen, mammogram if recommended, and contraceptive care. While most men need to go only to one physician, women usually go to a primary care physician for a medical check-up, as well as, a gynecologist.

Ms. Kramer said there is a moral responsibility to provide prenatal care because it effects the health of children. Also, this care is cost effective and saves money. She also supports coverage of elective abortions. Abortions is a safe legal procedure that cannot be separated from other procedures outside of religious or political grounds. It is not proper for this Task Force to repeal the mandate of the people (Question 6).

G. J. Rudow - DC Chapter, National Association of Women Business Owners

Ms. Rudow is the owner of Connections Travel, Co. which has just under 40 employees, 80% of which are female. She believes the plan needs to cover: an annual gynecological exam which includes a pap smear, a pelvic exam, a breast exam, and STD screening; along with counseling and family planning, contraception, estrogen replacement therapy, and a full range of reproductive service including elective abortions.

Abortion is a personal decision and should not be made by the employer. 13 out of 15 major plans in the state recently contacted cover elective abortions. Ms. Rudow also said the matter was settled by the voters. Furthermore, abortion is needed because contraception fails. Abortion coverage does not increase premium cost but actually lowers it.

H. Michael Gelman - Gelman, Rosenberg & Freedman, CPA

Mr. Gelman is the president of a mid-size accounting firm in Bethesda. He has 36 full-time and 2 part-time employees. He said high quality preventative care is necessary for business. For example, he offers flu shots to his employees and their families, because the business cannot afford to have sick employees during tax season.

Mr. Gelman has changed carriers several times over the past couple of years. He has seen premium increases as high as 22%. Women compromise 50% of his employees. A plan should cover routine gynecological exams. His current plan only covers the lab interpretation of a pap smear. Also, his current plan does not cover family planning services and counseling, which he believes ought to be covered. His current plan does, however,

cover elective abortions and sterilization. The plan is a PPO from The Travelers. The firm pays an annual premium of \$75,000. This does not include the employees' share.

I. Carol Trawick - Trawick & Associates

Ms. Trawick is CEO of a full service computer company with 45 employees. In order to attract and maintain well qualified employees, she needs to make her employees feel equal to those of larger companies. Originally, the company paid 100% of the premium. A year and a half ago, the company paid 90% of the premium. She has changed plans four times in the nine years of her company's existence.

Recently, Ms. Trawick instituted a new creative plan that is partially self-funded. She currently pays \$2,400 per person, which is a significant decrease from the past. She asked the Task Force why would our company want to enter the community rated pool if the standard benefit package does not offer as extensive benefits as ours and may cost more. Adequate coverage of mental health and pregnancy services is needed if the plan is to be bought by high tech companies.

Ms. Trawick said any business with 35 plus employees can do partial self-insurance. Her policy is from Home-Life, which offers a traditional indemnity or PPO. She pays a fixed administrative fee every month and puts aside the average amount of claims paid last year for that month. The policy pays claims out of the equity that has been built-up. Administrative costs are approximately 35% of the premium fee. The company's liability is \$10,000 per employee. The reinsurance plan kick in for claims over \$10,000. Part of the fee paid to Home-Life goes to reinsurance. Her company pays 75% of the premium for family members.

Mr. Barbera mentioned that since the plan is self-funded it does not need to obey the mandates. The cost of the plan seems low, however, we do not know if we are comparing "apples to apples."

J. Audrey Bracey - Planned Parenthood of Metro Washington

Ms. Bracey believes comprehensive reproductive health care coverage must be a cornerstone of the plan. Any plan with less coverage is a step backwards. Ms. Bracey noted women make up the majority of employees in small businesses. The plan needs to offer people a choice of providers, access to all forms of contraception, and coverage of elective abortions.

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K. Cede Johnston - Prospect Associates

Ms. Johnston is Director of Human Resources for a health education firm. This is a women owned company that has grown to 151 employees. Mr. Johnston stated the plan needs to cover prenatal, child wellness, and an annual gynecological exam. Ms. Johnston said that insurers view women up to age 49 as potential risks. Therefore, it is disadvantageous for employers to hire women and this promotes bias in the work place.

When she was shopping for plans for the company, the highest bids came from plans that did not offer wellness care. She believes such benefits are affordable in the HMO and PPO settings. For approximately 150 employees, her business pays \$300,000 for coverage. The company provides access to the plan for families and dependents, but does not pay any of their premiums. The premium costs per year for an employee are \$2,700 for the PPO and \$1,800 for the HMO. The company pays 100% of the premium for the HMO and 80% for the PPO.

Mr. Hillier said that the Task Force's \$3,500 limit includes the coverage of dependents. We are assuming that 2.1 persons are being covered for each employee. Ms. Johnston confirmed that the price she quoted does not include family members. She said her business would be interested in joining the pool.

L. Mina Schwartz - Vice Pres., Vocational Counseling Associates

Ms. Schwartz is one of four women partners in the business. When the business first became solvent, they wanted to provide health coverage for their employees. However, the health insurance environment makes this difficult. Health coverage cost well over \$3,000 per person. The company had particular trouble getting coverage for employees with pre-existing conditions. They had to get a sperate HMO policy for an employee with a history of mental health problems. Also, Ms. Schwartz said the business has received premium increase up to 20%. Notices of premium increases usually come in the mail just before renewal time, and often with no explanation attached.

Ms. Schwartz strongly believes preventative health care, as well as, adequate mental health services should be included; and that such care is cost effective.

M. Aileen Johnson - Member, Montgomery Co. Commission for Women

Ms. Johnson stated that the Commission for Women is a 15 member citizen advisory board. She advocated for the coverage of family planning including abortions, pap smears, maternity care, breast exams, and treatment associated with aging. Ms. Johnson said she supported the testimony of Ms. Bracey of Planned Parenthood. She also said the Task Force needs to consider language barriers and other impediments to access.

N. Kay Harkness - Silver Spring Business & Professional Women's Club (BPW)

Ms. Harkness is a small business owner and a single parent. Regular check-up that include a gynecological exam, pap smear, and mammogram is necessary to maintain health. People in her position do not have a lot of money for out-of-pocket expenses beyond the premium. Ms. Harkness said women run businesses are a fast growing sector of the economy, and the needs of women must be met.

O. Judy Mornoff - Montgomery Co. League of Women Voters

The League is in the second year of a study on the needs of children and families. Ms. Mornoff advocated for the coverage of preventative and wellness care, abortions, and family planning. She would also like to see hearing and dental plans, especially for children.

P. Dawn Stiles - Gaithersburg BPW

Ms. Stiles said she represents women entrepreneurs, self employed women, and employees of small businesses. She said preventative care, routine gynecological exams, counseling, abortions, mammography, and estrogen therapy must be provided. She wears a pink ribbon on her lapel as a reminder of the purpose for mammography.

Q. Molly Matthews - Matthews Communications

Ms. Matthews is an owner of a small business and works with her husband. Recently, she shopped for coverage for two employees. She could only afford a basic package that did not include maternity benefits and preventative care. According to Ms. Matthews, this lack of benefits does not make for happy employees. Ms. Matthews is in favor of greater mental health benefits. She believes this is not only humane, but will save money in the long run.

R. Helen Rieger - Corporate Secretary, Rieger Communications

Ms. Rieger is the Corporate Secretary for a custom photo lab. The company offers five different plans. In-vitro fertilization and artificial insemination is not covered because of the cost. Ms. Rieger believes prescription drugs must be included in the benefit plan, because if they are not, people will not have their prescriptions filled. She also feels that rehabilitation benefits are important.

Ms. Rieger said her company is partially self-funded. Health benefits only represent 10% of the payroll. Three years ago it was 12% of the payroll. With self-funding, Ms. Rieger said the company puts money away to pay claims, and what is left over at the end of the

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year is refunded to the employees. Mr. Barbera asked if this was a good incentive for employees to practice utilization review. Ms. Rieger believes that the refunds do not make much of a difference. She stated that it is the 10% to 20% copay which discourages over-utilization.

With partial self-funding, Ms. Rieger said 22% of the cost goes to administrative expenses. She pays \$6,500 per month for both administration and claims. The maximum liability is a \$25,000 per person and \$100,00 for the company. The plan also included dental and eye care.

Ms. Rieger said the business's previous health insurance company did not pay claims promptly. This hurt employees credit history. She answered in the affirmative, Mr. Hillier's question of whether there should be a standard for turn around time specified in the contract. Mr. Barbera said the law states that insurance companies have 30 days to pay. After this period, they must pay interest on the money owed.

S. Pete Holt - Dir., CORE Services of Montgomery County

CORE Services agencies manage mental health, and sometimes substance abuse services, in local jurisdictions through out the State. Mr. Holt believes the standard benefit plan should cover substance abuse and mental health services. This can be done with modest cost, by emphasizing non-hospital services. For example, Montgomery County has a crisis residential facility which is cheaper than a hospital. Mr. Holt mentioned case management, medication, medication management, non-hospital detox, intermediate care facilities, and partial hospitalization as non-hospital alternatives. People do not often need to be hospitalized, but unfortunately many of these non-acute services are not covered by various payors.

Mr. Holt said Montgomery County has a non-hospital detox unit. Only people with medical complications, this usually involves alcohol, use the hospital detox.

Mr. Holt said that children and adolescents need different coverage, such as expanded partial hospitalization and day services. According to Mr. Holt, it is best if services are delivered in conjunction with the school system. Mr. Holt also believes the 50% coinsurance for outpatient psychotherapy in Clinton's plan is too high. A rate of 25% to 30% is more appropriate.

T. Janet Baden - American Coalition of Nurse Midwives

Ms. Baden stated she agrees with all the previous speakers on women's health care. She suggested that using certified nurse midwives is an effective and efficient way to deliver such services. A Birth Center, is a place where nurse midwives deliver primary health care. Ms.

Baden said the primary focus may be pregnancy, but nurse midwives do gynecological exams, pap smears, etc. Nurse midwives are preventative care oriented. They do work with physicians when needed, such as when problems or abnormalities arise.

Ms. Baden said there are three birth centers in Maryland. They are located in Montgomery County, Southern Maryland, and Pikesville in Baltimore. The Montgomery County center has already delivered 4,000 babies. Ms. Baden said insurance companies are interested in the services of nurse midwives because they are cost effective. At birth centers, the charges are half of what physicians charge in a hospital.

According to Ms. Baden, Maryland has one of the most progressive Nurse Practice Acts in the country. In Maryland, nurse midwives have prescription privileges.

Ms. Breland asked if nurse midwives get reimbursed for preventative care. Ms. Baden said it depends on the insurance company. Mr. Barbera said that reimbursement will not be much of a problem in the future because carriers are looking for cheaper forms of care.

U. Graceanne Adams - Advocate for Infertility Treatment

Ms. Adams is a state employee. She said women in the workplace, contraception, and AIDs are three of the biggest social movements today. She said male infertility is not recognized by the State mandate.

According to Ms. Adams, the perception is that infertility treatment is an expensive luxury benefit. However, it is a normal human function to have children, and that very few people use in-vitro fertilization. Costs for such procedures are high because the technology is still relatively new. Prices should decline as the technology ages. Also, the procedure is exclusive because people have to pay out of pocket. If such procedure are covered, the price should go down because of greater volume. Ms. Adams also said women are marrying and having children earlier. This will lead to less demand because many of the current clients are women in their 30's trying to have children for the first time.

V. Peter Hirtle - Chairperson, Governor's Advisory Council on Hereditary & Congenital Disorders

Mr. Hirtle stated that untreated PKU will lead to extreme mental retardation. Children with PKU need to be on a low protein diet supplemented by medical foods. The FDA changed the classification of these supplements from a prescription to medical foods in order to increase research and lower costs. However, many plans do not cover non-prescription items, such as medical foods. According to Mr. Hirtle, BC/BS of MD and the WIC program do cover medical foods. He said no children in Maryland, to this point, have been denied access to such products.

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Mr. Hirtle believes that the coverage of medical foods needs to be specifically stated in the contract language. Currently, most patients purchase medical foods from the State, which acts as a cooperative buyer. Medical foods are administered under the supervision of dietitians and physicians. Mr. Hirtle said he had no objection if this supervisory requirement was written into the contract language.

For a 14 year old, the cost of medical foods is approximately \$6,000 a year for formula. However, Mr. Hirtle pointed out this does not include the cost of low-protein food products, such as low-protein flour, families most buy.

W. Mary Johns - President, MD Association of Cardiovascular & Pulmonary Rehabilitation

Ms. Johns believes cardiovascular-pulmonary rehabilitation should be covered in the standard benefit plan. The benefits of preventative care is not seen over a period of 8 to 10 years, but over a period of decades. She believes: cardiovascular-pulmonary rehabilitation should be given the highest priority; the focus of care needs to shift towards other medical specialties and away from just focusing on physicians; reimbursement needs to be based on outcomes; and more research needs to be directed towards preventative services.

X. Janet Gritz - MD Speech/Language Hearing Association

Ms. Gritz is a speech-language pathologist in Montgomery County. 2 million people, 17% of the population, has some form of speech-language or hearing problem. Speech-language services are not only essential for quality of life, but are cost effective. Ms. Gritz stated the Task Force has received several reports showing the small financial impact of such services.

Ms. Gritz said speech-language pathologist are independent allied health professionals. Insurance companies usually only cover care if given in a hospital setting. This is not very cost effective. Ms. Gritz believes that services should be reimbursed in all settings. Typically, coverage is only for problems related to illness or accidents. Many people, such as stutterers, are not covered because problems are not medically based.

When asked about the number of visits which should be covered, Ms. Gritz replied that formulating a strict numbers is problematic. Some patients require a few visits, while many require more extensive treatment. Ms. Gritz said treatment should have to show progress in order to be reimbursed. She believe typical cost sharing, such as 80% / 20%, is appropriate.

When pressed by the Task Force for a limit on the number of services, Ms. Gritz said 60 days of coverage like in President Clinton's health plan is generous. She also recommended Medicare's reimbursement requirement of re-evaluation after 60 days.

Y. Julie Howard - Maryland Occupational Therapy Association

Ms. Howard said she is testifying as a small business owner and as an occupational therapist. Occupational therapists treat and evaluate occupational injuries, and also treat how many occupy time. They assist patients in reaching their maximum level of independence. Occupational therapists are trained to work with people suffering from physical dysfunction and/or mental dysfunction.

Ms. Howard stated that rehabilitation saves money because it helps people regain independence. Therefore, society does not have to pay for attendant care and hospitalization. Also, family members do not need to drop out of the work force to stay at home in order to assist a person with their care needs.

Presently, outpatient occupational therapy is reimbursed; often by workers compensation. Ms. Howard said as a therapist she sees how OT helps people, and as a business owner she sees how OT gets people back to work.

Z. Donna Fitzpatrick - Radiance Services Co.

Ms. Fitzpatrick is an owner of a new small business. Currently, her employees have coverage from many different sources. She would like to get a group policy, but the current arrangement is more economical. Ms. Fitzpatrick advocated for the coverage of preventative care, women's health services, well-child care, and flexibility in choosing coverage. She believes abortions should not be covered unless to protect the life of the mother. She is morally opposed to abortion and believes it is different from other medical procedures. The other side's view that abortion is cheaper than prenatal visits and delivery is an unconscionable argument. Ms. Fitzpatrick said that according to that logic, we would have to ask why not shoot all ill people.

AA. Richard Israel - Maryland Speech-Language Hearing Association

Mr. Israel is an audiologist. He stated that it is well recognized that children and seniors have hearing problems. However, the people in between can also develop hearing loss. He sees an increasing number of young people suffering from hearing loss due to noise exposure.

Mr. Israel stated that audiologists are inexpensive providers. Coverage of their services only adds \$ 0.03 per premium payment. There are, however, barriers to access from insurance companies. Services are only covered if the patient is referred by a physician. Mr. Israel feels that direct access to audiological services is appropriate and cost effective. Currently many insurers and companies, such as the Federal government, allow direct patient access.

ITEM III

Report from Ad Hoc Work Group on Contract Language

Mr. Barbera introduced Sally Duran, from Kaiser Permanente, as the Chair of the Ad Hoc Work Group. Mr. Barbera told the audience that the Work Group was formed from industry representatives to help the Task Force develop uniform contract language. He said early on the Task Force felt that the recommendations for the standard benefit plan should be expressed in contract language. Mr. Barbera thanked the group, especially Ms. Duran, for their hours of work.

Ms. Duran said the task of developing uniform contract language initially seemed simple and straight forward. However, the task wound up to be extremely complex, because contracts represent each business's guiding principles and methods of operation.

Ms. Duran said the group identified points of common ground and tried to iron out industry issues. Ms. Duran then distributed the Work Group's recommendations to the Task Force. She said that the recommendations should be used as guidelines and that plans should be allowed to use their own language if it conforms to HB 1359. Ms. Duran feels the recommendations should help health care carriers and the Insurance Administration meet the July 1st deadline. Ms. Duran also said the group developed a list of general exclusions which they gave to the staff.

ITEM IV

Foster-Higgins Report

John Welch, Don Gasparro, and Jeff Gevlick of Foster-Higgins were introduced to the Task Force. They distributed and described the report, "Standard Benefits Cost Estimates, October 21, 1993, Version 1." Mr. Welch noted to the Task Force that a number of benefits when added to the baseline have minimal cost impact, so "0" was used. However, he warned that adding up many "0's" does not equal "0" because all benefits have some associated cost.

Mr. Gasparro walked the Task Force through the Pricing Exhibit, Attachment I, in the report. The numbers in the chart are factors that are multiplied with the baseline cost. For example "1.0" is representative of no change. The Pricing Exhibit allows the Task Force to see the cost effects of managed care, plan design, and individual benefits.

Mr. Welch noted that for the mental health and substance abuse options, the Task Force could not add or subtract the entire list from the baseline cost. Only one option each for inpatient and outpatient care can be chosen because the options are mutually exclusive.

Mr. Welch also warned that it is invalid to add up all the factors from various benefits and

then multiple the baseline cost by the sum of the factors. Also, he said that the Task Force cannot multiple repeatedly because the entire/combination effect is not known.

Mr. Hillier asked if Foster-Higgins took in account the future savings of preventative care. Mr. Gasparro said no, because the figures in the chart are only annual costs. Furthermore, Mr. Welch said that unlike Clinton's plan, everyone is not in the same pool. People are free to voluntarily leave the pool.

The Task Force began a general discussion concerning what overall cost level should they target for the standard benefit plan. Mr. Colmers said the trend in medical inflation is at least double the consumer price index (CPI). If we aim to be just under the ceiling for 1994 we will be in trouble for 1995. Dr. Cohen said the Health Care Access and Cost Commission would not want to have to come back next year and take away benefits.

Mr. Welch said the floor is \$2,997 (with 75% loss ratio) and the ceiling is approximately \$3,500. He told the Task Force the plan will have no trouble with meeting the floor, but it is too close to the ceiling.

Mr. Jaffein worried that the plan might not sell if the benefits are too reduced. Mr. Barbera said the Task Force needs foresight because an extensive regulatory process is required to change a benefit. Dr. Sammis reminded the Task Force that additional benefits can be offered as riders. She emphasized that business can always get more benefits but cannot get less benefits than the standard package.

ITEM V

Other Business and Adjournment

Mr. Barbera briefly described the structure of the next meeting scheduled for Saturday, September 23, 1993 at 9:00 a.m. on the Johns Hopkins University campus. Mr. Barbera suggested the Task Force should first generate guiding principles they would use in making their decisions. The starting point for developing such principles would be the statute (HB 1359) and the Governor's charge letter to the Task Force.

Dr. Sammis told the public that the minutes of the Saturday session will be made available on Monday, October 25, 1993. At the Thursday, October 28, 1993 meeting, the Task Force will be interested in hearing testimony concerning the decisions made at Saturday's session.

The meeting was adjourned at 8:50 p.m.

DRAFT

PUBLIC MEETING OF THE STANDARD BENEFIT PLAN TASK FORCE

OCTOBER 23, 1993

Co-Chairman Don Hillier called the meeting to order at 9:15 a.m. In attendance were: Co-Chairman Tom Barbera, Linda Breland, Arthur Ebersberger, Gerald Geffein, Rosalind Griffin, Dr. Lamb, Merson, Joan Paik, and Dennis Murray. Mr. Kerkhart joined the Task Force at a later time; Mr. Merson left after noon. *TO be corrected*

Commission staff was represented by: John Colmers, Alan Hoffman, Elizabeth Kameen, and Elizabeth Sammis. John Welch and Don Gasparro from Foster-Higgins were also present to assist the Task Force.

Mr. Hillier announced that this was a work session to decide what services to include in the comprehensive standard health benefit plan. He proposed that the members begin by discussing "guiding principles" to use when discussing various services, select the appropriate value for the floor and ceiling, and then discuss services.

ITEM I

The Task Force discussed possible designs for a health benefit plan. A benefit plan may provide individuals with comprehensive benefits and specify a dollar level beyond which the plan does not pay or a plan may provide coverage for catastrophic losses. While this choice exists for plans sold on an expense incurred basis by insurers it is not applicable in a managed care environment (e.g., HMOs).

In the small group health market the selection of benefit plans and their designs rests with employers and not employees. Lower income employees are more interested in the cost of routine care; upper income employees are more concerned about protection from catastrophic losses. Within a given firm, then, an employer may have employees with different needs but the employer can only select one plan.

A benefit plan may provide a medical package or a health package. A health package emphasizes primary/preventive care.

The Task Force then reviewed the statute. The statute specifies a floor and a ceiling for the benefits: the benefits can be no less than the actuarial equivalent of the minimum benefits required to be offered by a federally qualified HMO and the average community

rate can be no more than 12 percent of Maryland's average annual wage. The Task Force asked Foster-Higgins to comment on the term "actuarial equivalent". Foster Higgins noted that for plans to be actuarially equivalent they must be the same economic value. The economic value can be limited to the services or include cost-sharing. For example the minimum benefits required to be offered by a federally qualified HMO within an HMO is equal to \$2997 assuming typical co-payments. The same services and co-payments in an indemnity plan is equal to \$4600 but no indemnity plan would only specify co-payments and not other cost-sharing arrangements.

The Task Force then discussed whether the statute bound the Commission to cover all the benefits required to be offered by a federally qualified HMO. The Task Force concluded while the Commission was not bound to do so if a required benefit was eliminated this might force federally qualified HMOs out of the market or make it more difficult for them to compete.

The Task Force turned to the question of what target should be used to determine the economic value of the comprehensive standard health benefit plan. The members agreed that the value should be such that the Commission could reasonably expect the average community rate to not exceed 12 percent of Maryland's average annual wage for at least a three year period (1994 to 1996).

The Task Force members agreed to the following:

- the comprehensive standard health benefit plan should offer a health package rather than a medical package;
- the comprehensive standard health benefit plan should specify services and not particular health care providers;
- the services should be the same across types of plans (indemnity, PPO, POS, HMO) with the economic value of the plan kept the same by varying the cost-sharing arrangements;
- the included services should not place federally qualified HMOs at a disadvantage vis a vis other carriers;
- the target for the economic value of the comprehensive standard health benefit plan should be \$3034;
- the services and cost of the plan should be balanced to encourage small employers to offer the comprehensive standard health benefit plan to their employees; and
- services should be included or excluded based on the criteria noted in the statute and the uncoded section of HB 1359.

ITEM II

The Task Force members then discussed each of the services to be included in the comprehensive standard health benefit plan. A vote was taken only when a consensus was not reached. The Task Force agreed to the following services and limitations:

1. Inpatient Hospitalization: 365 days
2. Mental Health: Carriers must provide mental health benefits in a managed care environment. This means that carriers must establish a "gatekeeper" for such services. The comprehensive standard health benefit plan would provide 20 inpatient days per year and unlimited outpatient days.

For this one service the Task Force specified a cost-sharing arrangement. Plans sold on an expense-incurred basis and HMOs must have the following cost-sharing arrangements for outpatient mental health services: 1 to 7 visits, the plan pays 80 percent of the cost; 8 to 30 visits, the plan pays 65 percent of the cost; 31 + visits, the plan pays 50 percent. On the inpatient side, the plan pays 80 percent of the cost. The Task Force recognizes that this means carriers will pay the specified percentage for "allowed" charges. The Task Force did not place any out-of-pocket limits or deductibles for this service in HMO plans.

3. Emergency Room Services: \$50 copayment or applicable coinsurance amount whichever is greater. Amount waived if admitted to a hospital. (6 -3 vote)
4. Outpatient Hospital Services and Outpatient Surgery: Covered with a \$25 copay for HMOs
5. Preventive Services: The Comprehensive Standard Health Benefit Plan must include the services recommended by the U.S. Preventive Task Force.

Carriers may not impose any cost-sharing from the ages of 0 to 6.

The Task Force will recommend that the Commission establish a mechanism to periodically review the appropriateness of these services.

6. Home Health Care: 40 visits (as an alternative to hospitalization)
7. Hospice: Same as Medicare (Limitations: only for terminally ill individuals as an alternative to hospitalization)
8. Durable Medical Equipment: Reimbursed at 80 percent across all plans. Covered services include DME, prosthetic devices (other than dental), leg, arm, back and neck braces, artificial legs, arms and eyes, and training. The equipment must improve functional abilities or prevent further deterioration in function and does not include custom devices.

9. Outpatient Laboratory and Diagnostic Services: \$20 copayment or applicable coinsurance amount whichever is greater
10. Pregnancy/Maternity: The Task Force held an extensive discussion as to whether this service should include abortions. A motion was first made to include all abortions with no limitations. The motion carried on a 5 to 3 vote with 1 abstention and 1 absent. Then a motion was made to reconsider this vote. The motion for a reconsideration carried.

A new motion was made to include in this service all medically necessary abortions with medical necessity determined solely by the patient and their health care provider. The motion carried on a 7 to 2 vote (Joan Paik and Tom Barbera asked to be officially recorded as in the negative).

11. Outpatient rehabilitation services: Outpatient occupational therapy, physical therapy, and speech-pathology services for the purpose of attaining or restoring speech. Coverage only for therapies used to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury. At the end of each 60 days of treatment the need for continued therapy is re-evaluated.

\$20 copayment or applicable coinsurance amount whichever is greater

12. Skilled Nursing Facility: As an alternative to hospitalization and a 100 day limit.

\$20 copayment or applicable coinsurance amount whichever is greater

13. Infertility: \$5,000 per calendar year for a maximum of 5 years. Excludes in vitro fertilization or gamete intrafallopian transfer
14. Prescription Drugs: The Task Force extensively discussed whether to include this service. The motion to exclude prescription drugs failed on a 4 to 5 vote.

The Task Force then agreed to have Foster-Higgins price the plan with no prescription drugs and with a \$250/ year deductible and a 20 percent coinsurance amount for generic substitutes

15. Nutritional Services: Nutritional services available when a licensed physician determines that nutritional services are medically necessary for treatment of cardiovascular disease, diabetes, malnutrition, cancer, cerebral vascular disease, or kidney disease. Limit of 6 visits per condition per year.
16. Medical Food: Coverage for particular genetic, metabolic disorders (e.g., PKU). (Staff to specify particular disorders)
17. Family Planning Services: Limited to counseling (7 to 2 vote)

18. Cleft Lip and Palate: Coverage for inpatient or outpatient expenses arising from orthodontics, oral surgery, otologic, audiological and speech/language treatment involved in the management of birth defects known as cleft lip and palate.
19. Joint Manipulations (Staff to find appropriate term to define chiropractic services)
20. Blood and Blood Products: Carriers may not exclude payments for blood products, both derivatives and components. May exclude whole blood or concentrated red blood cells. (Staff to verify this would cover products needed for hemophiliacs)

ITEM 111

The Task Force also discussed cost-sharing arrangements.

1. For HMOs : \$20 copayment for all services except mental health, well-child care, and outpatient hospital and outpatient surgery
2. For insurers and nonprofit health service plans: Foster-Higgins will advise the Task Force as to the necessary cost-sharing arrangements needed for traditional indemnity plans, PPOs, and POS to keep within the target of \$3034

ITEM IV

The staff discussed the schedule for the remainder of the time. Foster-Higgins will try to get the cost of the plan to the members by next Tuesday. Prior to public testimony next Thursday, Foster-Higgins will report their findings and the Task Force will make any decisions on possible design modifications. The staff will distribute a draft report at the next meeting. The staff will try to arrange an earlier start time for the last meeting Saturday October 30. The staff will prepare a list of exclusions for the Task Force to consider.

The Task Force meeting adjourned at 5:20 p.m.

**11th PUBLIC MEETING OF THE
STANDARD BENEFIT PLAN TASK FORCE**

October 28, 1993

Co-Chairman Don Hillier called the meeting to order at 4:20 p.m.

In attendance were: Co-Chairmans Thomas Barbera and Don Hillier; and members Linda Breland, Arthur Ebersberger, Rosalind Griffin, Gerald Jeffein, Joseph Kerhart, Dr. William Lamm, J. Dennis Murray, Joan Paik.

Staff Present: Executive Director John Colmers, Deputy Director Elizabeth Sammis, Ann Rasenberger, Hal Cohen, Ph.D. and Alan Hoffman.

ITEM I

New Assumptions Developed by Staff

Mr. Colmers announced that the cost of the plans, \$3391, was 11.8% above the target of \$3034 set on Saturday, October 23, 1993. The Task Force also expressed the desire Saturday to have the plan cost the same for each delivery system. After much thought, Mr. Colmers stated, the staff now proposes to meet the target through a weighted approach.

The first new assumption made is that the indemnity product will account for 10% of the market, while the PPO, POS, and the HMO products will each attract 30% of the market. Under this new weighted averaged assumption, the average cost of the plans decreased from \$3391 to \$3316.

The new market share assumption also effects the medical cost trend line factor of 12% that was used October 23rd to determine the cost target. The new trend line, where indemnity plans only account for 10% of the market, is now 11.2% per year. Using this new medical cost inflation factor along with a projected 4% wage inflation rate raises the SBPTF cost target from \$3034 to \$3078. With the new assumptions, according to Mr. Colmers, the Task Force is 7.8% above target, rather than 11.8%

Mr. Colmers also stated the following figures for employees' out-of-pocket costs (copays, coinsurance, and deductibles) and their percentage of total costs:

- Indemnity = \$1,261 (25.1%)
- PPO = \$1,010 (23.2%)
- POS = \$611 (15.6%)
- HMO = \$395 (11.1%)

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Mr. Barbera motioned to accept the staff recommendations of market segmentation (Indemnity = 10% and PPO, POS, & HMO = 30% each) and a 11.2% medical plan inflation trend line. The motion was seconded and passed by unanimous consent.

Mr. Colmers told the Task Force that in order for the plan to cost the same in every delivery system, extremely high cost sharing would be required for the less managed products. There was a brief discussion by the Task Force concerning the adverse selection that would occur if the plans were price differently.

Mr. Ebersberger motioned that the plan be price the same for all delivery systems. The motioned was seconded and failed to be approved by a vote of 2 to 8. Then, Mr. Kerhart motioned that all plans be priced differently. This motion was seconded and approved with one abstention.

Mr. Colmers stated that on October 23, 1993 the SBPTF imposed a minimum \$20 copay on all services, except for HMO well-child care ages 0 to 6 years old. The staff has been notified that this might be in conflict with the Federally Qualified HMO regulations. According to the regulations, copays cannot be more than 50% of any one service or greater than 20% of the aggregate services. Therefore, the staff recommends that primary care copays including well-child care be set at \$10. The effect of this is to increase the cost of the HMO product. Therefore, the new weighted average for all products increases from \$3316 to \$3330.66. The SBPTF is now 8.2% above the target.

Ms. Breland stated she would like to see no copay for well-child care. Mr. Barbera responded that there is no experience that shows a \$10 copay is a barrier for well-child care. He also stated there is a value to keeping all copay levels the same for administrative purposes.

Mr. Colmers told the Task Force that they did very little last meeting to get close to the target. The Task Force would have to increase cost sharing and/or decrease benefits. Mr. Colmers announced that the staff has come up with following suggestions to close the 8.2% gap:

1. Limit physical therapy, outpatient rehabilitation, and chiropractic services to 10 visits a year.
2. For the prescription drug plan use Clinton's High Cost Sharing option for all delivery systems. This entails a separate \$250 prescription drug deductible with an 80% / 20% coinsurance rate.
3. Since, measure 1 and 2 will still leave the cost above the target, ask Foster-Higgins to increase the cost sharing until to the target is reached.

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Mr. Colmers stated there are various reasons for including a prescription drug plan in the standard package. First, it prevents adverse selection. Second, since most employers want a prescription drug plan and would acquire it as an optional rider, the Task Force would be just playing a shell game if prescription drugs were eliminated to meet the \$3078 target. The staff choose the President's High Cost Sharing Option because it protects individuals from substantial losses. However, the majority of people, with one or two prescriptions a year, will never get beyond the deductible.

Mr. Barbera reminded everyone that employers can get riders to enrich the benefits by lowering the prescription drug deductibles. He warned that if the benefit level is set too high, we run the risk of telling some employers that their current benefit is not enough. These employers might not be able to afford this richer benefit package.

Mr. Barbera motioned for Foster-Higgins to price out the \$250 prescription drug deductible with 80% / 20% coinsurance rate for all plans including HMOs. The motion was seconded and approved with unanimous consent.

ITEM II

General Exceptions

Dr. Sammis presented the Task Force with a list of general exceptions. Most were taken from the State of Kansas's minimum benefit package. Mr. Barbera mentioned that this was a list of general exceptions, hence, it should have no actuarial effect on the package. The Task Force agreed to review the list on a page by page basis.

Ms. Griffin wished to eliminate the exception, "services and supplies related to voluntary sterilization," on page 2. Dr. Lamm motioned to delete this exception from the list of general exceptions. This motion was seconded and passed on a vote of 6 to 3.

Ms. Breland asked fellow Task Force members the reason for the exclusion on page 2, "maternity services for dependent children except for complications of pregnancy." Mr. Ebersberger stated the reason was cost. Furthermore, the dependent child and baby would be considered a new and different family unit and household. After consulting with Foster-Higgins, Dr. Cohen told the Task Force that maternity services for dependent children was included in the cost calculations. If this service was to be excluded, it would result in a savings of 0.1%.

Mr. Ebersberger motioned to eliminate the exception on dependent children maternity services. The motion was seconded and passed with unanimous consent.

Ms. Breland asked the staff to clarify the meaning of the language on the second exception on page 2 that states, "in vitro fertilization . . ." Since no one present knew the precise

meaning of all the technical terms, the decision on this exception was tabled to Saturday's meeting.

On page 3, it was brought to the staff attention that the exception on non-human organs and their implantation had to be clarified because it was written as a double negative. Furthermore, the last exception on page 3, "durable medical equipment except those authorized," can be deleted as unnecessary.

After some discussion the Task Force agreed to delete the exception, "whole blood, blood plasma, or blood serum except for hemophiliacs," because it will be dealt with in benefits section.

There was further debate on the organ transplant exception listed on page 3. Mr. Colmers announced that all transplants listed as being exempt from the exception (meaning those covered) were costed by Foster-Higgins except autologous bone marrow transplants. Foster-Higgins assumed that only non-autologous bone marrow transplants would be covered. The staff was directed to clarify the language on which transplants were covered and not covered.

Mr. Kerhart expressed his desire to cover the nicotine patch for smoking cessation purposes. The Task Force agreed that this would be covered as part of the prescription drug plan. In order to assure the coverage of the nicotine patch, it was suggested that, "accept as otherwise provided in the plan," be added to the end of the second exception of page 4.

Mr. Barbera motioned to accept all changes just discussed for pages 1 to 4 in General Exceptions. The motion was seconded and approved with unanimous consent.

Dr. Sammis told the Task Force she deliberately left out the following commonly found exceptions from the list:

- Deliberately inflicted wounds and injuries; and
- Chronic mental health conditions that are un-treatable.

Mr. Hillier also mentioned the following common exception he found during his research:

- Charges obligated person does not have to pay;
- Injuries sustain while participating in a professional sporting event or a dangerous professional advocacy;
- Charges refused by another plan for non-compliance;
- Services provided by physician or provider enrolled in training or educational activities, and those services are primarily for training purposes; and
- Charges above usual and customary.

After some discussion there was a motion by Ms. Paik to add the following exclusions to the General Exception list: 1) deliberately inflicted wounds and injuries; 2) injuries sustain while participating in a professional sporting event; and 3) charges a person has no obligation to pay. The motion was seconded and was approved with unanimous consent.

ITEM III

Foster-Higgins Report

While the Task Force discussed general exceptions, Foster-Higgins was pricing out the previous Task Force recommendations. The new assumptions were: 1) \$10 HMO copay for primary care visits, and \$20 copay for all others; 2) limit chiropractic, physical therapy, and outpatient rehabilitation to 10 visits; and 3) President Clinton's High Cost Sharing Option for prescription drugs.

Foster Higgins also varied the cost sharing of each plan in order to reach the weighted average cost target of \$3078. (See Attachment for details.)

For the PPO delivery system, Mr. Ebersberger recommended the second option with the lower deductible but less favorable co-insurance rate. The lower deductible made it a more marketable product. Mr. Ebersberger made a motion to adopt the second cost sharing option for a POS product. The motion was seconded and passed with unanimous consent.

Mr. Welch of Foster-Higgins commented that the POS is probably the weakest product because its cost-sharing is so high. He, however, stressed that this is just the baseline and carriers can offer richer benefits. Dr. Sammis reminded the Task Force that POS was defined as an indemnity based plan rather than an HMO base plan. The rationale for this decision is that a POS option for an indemnity plan would be a negative rider and would not be congruent with the community rated system.

Mr. Barbera instructed the staff to specify in the final report that an HMO which offers a POS wrap in the small group market should be exempt from Maryland Mandates.

Mr. Barbera told the audience that the Task Force wishes testimony on the 10 visit limit versus possibly having a sliding scale for chiropractic, physical therapy, and outpatient rehabilitation. This scale would be similar to the one used for outpatient mental illness services. (1-5 visits = 80%; 6-30 visits = 65%; and 31+ visits = 50%) Mr. Welch confirmed that the 10 visit limit and a sliding scale had approximately the same actuarial impact.

Mr. Barbera made a motion to enact all changes discussed up to this point with leaving open the sliding scale versus 10 visit limit. The motioned was seconded and passed with unanimous consent.

ITEM IV

Public Testimony (Excluding Abortion)

A. Andrew Wigglesworth - Maryland Hospital Association

Mr. Wigglesworth stated that this plan was a precursor to a possible plan for the total market. What does not get covered here will become charity care and bad debt in hospitals. He commended the Task Force for covering 365 days of inpatient hospitalization. However, Mr. Wigglesworth said he had some concerns. He felt decreasing the inpatient days for mental illness from the 30 days of the Maryland Mandate to 20 days penalizes the severely mentally ill. He also expressed displeasure with the \$50 copay for the emergency room. He suggested the copy be lowered to \$25 or at least the \$50 be applied towards the deductible.

B. Dr. Neil Friedman - MD Dir., American Cancer Society

Dr. Friedman stated he is a physician at Hopkins who treats breast disease in women. He stated that the guidelines for mammography are controversial, and he cannot agree with the new U.S. Preventative Services Task Force Guidelines. Just this month, he has taken care of five women under 50 years old with breast cancer. The malignancies in these women were all detected by mammography. The only area of progress in breast cancer has been early detection. He stressed the need to screen women before 50.

C. Daniel T. Doherty, Jr. - Pharmaceutical Manufacturers Assoc.;
and the Maryland Society of Oral and Maxillofacial Surgeons

Mr. Doherty stated that 96% of employer provide insurance plans provide a prescription plan, and only 9% require a deductible. Prescription drugs are cost effective therapy. A high deductible encourages prescriptions not to be filled. Mr. Doherty believes there should not be a separate deductible for drugs. He would recommend raising the overall deductible in order to abolish the prescription deductible. He also believes that the increase in the comprehensive deductible does not have to be the complete \$250 (a dollar for dollar increase) in order to make the change cost neutral.

As the representative of oral and maxillofacial surgeons, Mr. Doherty believes the coverage for oral surgery is not well defined in the plan. He said there is a large degree of provider discrimination present. Patients have been denied coverage of work done by oral surgeons. The same treatments would have been covered, however, if performed by a M.D.

D. Jack Benigni & Steve Altowitz - MD/DC Society of Respiratory Care

Mr. Benigni and Mr. Altowitz were concerned that the durable medical equipment benefit does not include home oxygen and respiratory services. Mr. Colmers asked if such services were included Clinton's plan? They responded yes, and Mr. Colmers said then such services are included in the standard benefit plan. Mr. Barbera suggested they write a letter to the Commission documenting this conversation.

Mr. Benigni and Mr. Altowitz stated that respiratory care professionals need to be reimbursed for home care. Reimbursement is needed if more care traditionally done in an acute setting is to be moved to the home care setting.

E. Paul D. Brant - MD Optometric Association

Mr. Brant says he is aware that vision insurance for such things as eye glasses and contacts is excluded from the plan by HB 1359. However, he assumes that routine preventative eye care is covered. He advocated for the coverage of screens for children up to the age of 18. He also said that provisions need to be made for people in high risk categories, such as diabetics. Mr. Brant also advocated for the coverage of hard contact lenses for patients with thinning of the cornea. He said he would send appropriate language to the staff.

F. Alice Neily - National Medical Enterprise

She was encouraged about the use of managed care. She disagreed with the exception from coverage of deliberately inflicted wounds and injuries.

G. Charles Gerhardt - Communication Workers of America

Mr. Gerhardt distributed a health plan offered to Bell Atlantic employees for the Task Force's information. He stated it is an indemnity plan which is competitively priced with HMOs.

H. Casey Ann Hughes - MD Psych. Assoc.

Ms. Hughes congratulated the Task Force on its innovative coverage of outpatient mental health services. However, she was not thrilled with 20 inpatient days and the exclusion of self-inflicted wounds. Suicide, according to Ms. Hughes, is the second leading cause of death among adolescents. It is cruel not to cover the injuries of a failed suicide attempt. Ms. Hughes said she is willing to accept the exception from coverage of un-treatable mental illnesses.

I. Barbara Brocato - American College of Emergency Physicians

Ms. Brocato suggested the definition of an emergency is the best deterrent to improper usage of the emergency room. The current definition in state law is a well thought out symptom based definition. If an enrollee's symptoms does not meet this definition, then they will be responsible for the entire emergency room bill.

J. Frank Goldstein - MD Psychiatric Association; Suburban MD Psychiatric Association; MD Association of Chain Drug Stores

Mr. Goldstein asked the Task Force to cost out the different between 30 versus 20 inpatient mental health days. Mr. Goldstein agrees with the current prescription plan. It provides coverage for those in catastrophic situations.

K. Fran Tracy and Joe Pescrille - BC/BS of MD

Ms. Tracy and Mr. Pescrille believe the cost target was set too low by the Task Force. Also, they believe Foster-Higgins' cost calculations are too low. Further, they are afraid if the benefits of the plan are too low, it could create a class of under-insured people. Mr. Barbera reminded the testifiers that employers can always buy additional coverage. Ms. Tracy responded that employers will see this as the standard and not buy additional benefits.

Mr. Pescrille stated he would like to see the cost sharing burden of the plans decrease. Mr. Colmers did not understand the testifiers logic. If the Foster-Higgins' cost calculations are, as you say, too low and the Task Force decreases cost sharing, the plan will never be in compliance with the 12% of wages ceiling. Mr. Colmers stated that the cost target was set low enough to allow the plan to be under the ceiling for two years. This was done so the plan would not have to be changed every year.

The Task Force asserted it was trying to make the product affordable. It was attempting to bring coverage to people who currently do not have insurance.

L. Robert White - MD Addiction & Recovery Coalition

Mr. White said the Coalition represents many groups. He said aggressive substance abuse treatment saves money on the medical side. 50% of Shock Trauma's admissions are substance abuse related. He believes most people can be treated as outpatients, but the inpatient option needs to be available when appropriate. Furthermore, he believes that substance abuse should be separated from mental health services. A day in a substance abuse treatment center costs considerably less than a day in a psychiatric hospital.

Mr. White is also concerned about the managed care aspect of the plan. The managed care tag line means many different thing. For substance abuse, it often means no care.

M. Sally Duran - MD Association of HMOs

Ms. Duran said there were some discrepancies between the standard benefit plan as it is defined now and the benefits federally qualified HMOs (FQHMOs) are required to offer. Home health visits are capped at 40 in the standard benefit plan. FQHMOs are required to offer unlimited benefits. Also, FQHMOs are required to offer short-term rehab for 60 days.

Ms. Duran also said the infertility treatment services cap would be hard for HMOs to measure because it does not coincide with copays. She also does not see how an HMO can exclude self-inflicted injuries.

Ms. Duran said the Task Force needs to clarify that the \$20 copay is per visit not per test. She said Kaiser, her employer, has had success in reducing high risk pregnancies by waiving copays for prenatal care. She also did not like the fact that according to Foster-Higgins calculations, the HMO plan is the most expensive product. She would like to see the delivery systems be closer in costs with each other.

N. Miles Cole - MD Chamber of Congress

Mr. Cole reminded the Task Force that the plan would be useless unless bought. The plan cannot afford to cover everything. Employers can always buy additional benefits. Mr. Cole said only time will tell, if the Task Force succeeded in making the plan affordable.

O. Randy Cooper - MD Occupational Therapy Association

Mr. Cooper said he was testifying on behalf of Pat Brokos. He is concerned about imposing a 10 visit limit. Some patient will be unable to achieve their goals in 10 visits. Mr. Cooper also sees problems in using the scaled reimbursement. The 50% co-insurance rate after 30 visits is unaffordable for many individuals, especially because by the 31 visit he/she usually has been out of work for a long time.

Mr. Cooper expressed his preference for the sliding scale over the 10 visit limit. He also expressed problems with the exception on inpatient admission primarily for physical therapy.

P. Dr. Judy Iarocino - Md Chapter, American Speech & Hearing Association

Dr. Iarocino stated she is a small business owner, Maryland NeuroRehab Center, and a speech-language pathologist. She said there is a need for the plan to cover comprehensive rehabilitation services. The ideal mode of overview is a case management approach.

Q. Kira Layng - Maryland NeuroRehab Center

Ms. Layng discussed the benefits of rehabilitation in returning people back into productive members of the community. Reimbursement for day programs are necessary.

R. Ed Lyons - MD APTA

Mr. Lyons is a director of physical therapy at a skilled nursing facility. He had the following concerns: the exclusion of inpatient admissions primarily for physical therapy; the 10 day limit or sliding scale for physical therapy; the exclusion of orthotic devices; and the grouping of physical therapy with chiropractic services.

S. Jay Schwartz - Med Chi

Mr. Schwartz distributed copies of the October 1993 GAO report "Managed Health Care: Effect on Employers' Cost Difficult to Measure." He highlighted a graph on page 14 that shows Foster-Higgins estimates for network-base managed care plans premiums in relation to indemnity plan premiums was different than those of Peat Marwick and Health Insurance Association of America.

Mr. Schwartz also questioned the medical inflation assumption of 12%. He asked the Task Force to cost the plans using different assumptions for comparison purposes. He told the Task Force that they had a window of opportunity. Unfortunately, he said the Task Force "choose a consultant that put handcuffs on you."

Mr. Schwartz also did not agree with the emergency room copayments, the exception for self-inflicted injuries, and the lack of mammography screening for women under fifty.

T. Bobbi Seabolt - MD Women's Health Coalition; and the American Academy of Pediatrics

As a representative of the Maryland Women's Health Coalition, she agrees with the testimony of Dr. Friedman.

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As a representative of the American Academy of Pediatrics, she cannot concur with the U.S. Preventative Task Force Guidelines. Ms. Seabolt stated there was no pediatrician on the Preventative Task Force, and that children are just a footnote in the report. Members of the U.S. Preventative Task Force have told her that document was never meant to be used as a guide. Ms. Seabolt recommended the Task Force use the federally qualified HMO regulations in the area of preventative services for children. She believes there would be no actuarial difference.

Ms. Seabolt stated that family planning is cost effective. She would like to have contraceptive prescriptions and devices covered outside of the prescription plan.

Ms. Seabolt expressed concern that the exception on page 3 for dental work. She wondered if it might conflict with treating children with cleft lip and palate. She also expressed concern about the copay for emergency room visits. She believes the definition of emergency is enough to discourage improper use. She also agrees with the mental health groups on eliminating the self-inflicted wound exclusions. She also would like to see smoking cessation covered because it is a cost effective benefit.

Ms. Seabolt said, she agrees with Blue Cross and Blue Shield of Maryland and Jay Schwartz from Med Chi, that the Task Force has wiggle room to add additional benefits.

U. Rick Sampson - Alcohol & Drug Abuse Admin., DHMH

Mr. Sampson told the Task Force that substance abuse impacts medical costs. Treatment for substance abuse will reduce overall health expenditures. Mr. Sampson said the current plan only offers high end acute care treatment and low end outpatient services. A step down between acute and outpatient care is what is needed.

Mr. Barbera said the standard benefit plan allows for case management systems. He asked Mr. Sampson to fax the Task Force language that is necessary to assure these step down units are covered.

V. Joel Kruh and Dr. Marc Gammerman - MD Chiropractic Association

Mr. Kruh told the Task Force there are 300,000 chiropractic patients in the state, and over 7,000 small business cover chiropractic care. He said the Chiropractic Association favors the sliding scale over the 10 visit limit. However, Mr. Kruh said the standard benefit plan is not giving chiropractors a level playing field. The plan tells individuals that they will get less coverage for chiropractic care than if they pursue medical care under a physician.

Mr. Kruh said he gave the Task Force a number of reports, especially an Ontario study called The Magna Report, that demonstrated the cost effectiveness of chiropractic care. Mr. Kruh expressed his hope that there is enough wiggle room to level the playing field.

Dr. Cohen commented that he recently attended an Office of Technological Assessment (OTA) conference where back manipulation was discussed. According to the research, manipulation is the only back treatment that actually helped. Dr. Cohen explained that it is not a question of does manipulation work, but a question of what can we afford.

W. Ken Armstrong & Kathy Smith - American Red Cross

Mr. Armstrong and Ms. Smith distributed written testimony to the Task Force. They stated that the Red Cross does not levy a fee for blood but charges a processing fee. Mr. Armstrong said there is a lot of competition in the field, therefore we must keep our costs down.

The Red Cross is not in favor of a non-replacement fee because some people cannot give blood and others with high risk behavior might lie in order to avoid the fee. Ms. Smith distributed to the Task Force language that could be used in the standard benefit plan. She admitted that currently this language is not used by plans, however, it is an accurate portrayal of what is actually being practiced.

X. Dr. Anne Winner - School Psychologist

Ms. Winner talked in support of more mental health coverage, specifically increasing inpatient hospitalization to 30 days.

ITEM V

Public Testimony of Coverage of Elective Abortions

A. Pro-Abortion Coverage

> Constance Baker

Ms. Baker stated she is a lawyer with Venable, Baetjer and Howard, and is counsel to Planned Parenthood of Maryland. She advocated the deleting of "medically necessary" and returning to the language of the original abortion motion passed on October 23, 1993. Ms. Baker then listed the following reasons supporting her position:

- A special "medically necessary" test does not apply to other pregnancy services.

- Since there is no consensus on "medically necessary," this will lead to a patchwork approach. This is against the General Assembly wish for uniformity.
- In HB 1359, one of the criteria was to consider benefits already being offered. Coverage of elective abortions is already the status quo.
- The language requires that physicians on an individual basis agree to the abortions of their patients. Currently, these decisions are made at the plan level.
- This language could chill physicians willingness to perform abortions.

Ms. Baker recommended the language "pregnancy and maternity services including abortions."

> Dr. Steven Adashek

Dr. Adashek advocated for the inclusion of contraceptives. He believes that a \$10 copay for prescriptions is better than a \$250 deductible. He also recommended that patients get some coverage for infertility procedures.

Dr. Adashek said the use of the term "medically necessary" causes confusion for providers.

> Julia Steinberg

Ms. Steinberg said she works for Cigna processing indemnity and PPO claims for self-funded plans. Most plans, 9 out of 10, do not have limitations on abortions. The "medically necessary," language usually requires additional medical documents to be filed in order to get the claim paid. Ms. Steinberg said the current language in the plan would require her to send a letter to a women asking for documentation of the "medical necessity" of her abortion.

> Joanne Salzberg

Ms. Salzberg is the Executive Director, Maryland Commission for Women. She spent 20 years in the insurance industry in the small business market. She does not favor language that "muddies up" plan administration. She stated that 75% of women make under \$25,000 and will have trouble affording this plan. She asked the Task Force to look at other actuarial models that have first dollar coverage of wellness visits.

> June Chaplin

Ms. Chaplin is a professional photographer with two employees. She wants access to abortions regardless of her physician's opinion.

> Carol Horst

Ms. Horst is here representing American Association of University Women. She testified in favor of coverage for preventative care and elective abortions.

> Elaine Weintraub

Ms. Weintraub is representing the National Council of Jewish Women. She told the Task Force that women have more parts than men and therefore need more basic services. She does not see how a plan could say we cover breasts, but not contraceptives. She recommended the Task Force take away any language that prevents women from choosing to have an abortion in consultation with her doctor.

> Agnes Edwards

Ms. Edwards represents the League of Women Voters and the Maryland Chapter, National Association of Social Workers. She supports the inclusion of abortion. She is concerned that the present language implies limitations. The Governor's Committee for Welfare Reform recently recommended that medical assistance start funding abortions to correct a recognized discrepancy in access.

> Dr. Anne Winner

Dr. Winner represents the Maryland Coalition for Abortion Rights, a religious coalition that supports a women's right to choose. She briefly talked about the history of women's rights. She said there were many benefits the package specifically covers that might not be considered "medically necessary."

B. Con-Abortion Coverage

> Roger Stenson

Mr. Stenson is the Executive Director, Maryland Right to Life, Inc. He said that Foster-Higgins was quoted in the St. Louis Dispatch as saying that coverage for elective abortions

is not common in self funded indemnity and PPO plans, and that it is only common among HMOs. Mr. Stenson said the plan is not affordable to many people, because its cost is the death of thousands of human fetuses. Mr. Stenson argued that abortion should be an optional rider. This we give people a choice not to pay for other people's elective abortion. Mr. Stenson distributed written testimony from Thomas P. Sheahen, Western Technologies, Inc to the Task Force.

> Bill Wingard

Mr. Wingard is a manufacturer in Baltimore City with 20 employees. He is a member of the Catholic Church and will not pay for insurance that covers abortions.

> Charles Whalen

Mr. Whalen announced that he is a Maryland citizen, but does not have any employees. He told the Task Force that abortion is not health care. He stated that many people are morally opposed to it and will not purchase a health plan that covers it. He quoted a CBS/NY Time poll that found 72% of people oppose covering abortion in President Clinton's basic health package.

> Franklin Knipe

Mr. Knipe is a owner of a business that does third party administration. He told the Task Force that many insurance companies and self-insured plans exclude self-inflicted injuries and abortions. He recommended abortions be an option. This would coincide with the Task Force efforts at keeping costs down.

> Kevin Appleby

Mr. Appleby is from the Maryland Catholic Conference. The Conference supported the enactment of HB 1359. He asked the Task Force to look at the impact of increasing mental health inpatient hospitalization to 30 days. Mr. Appleby said the goal of the legislation is to cover the uninsured and to sell this plan to employers. He said the Task Force should not make inclusions that discourage sales.

> Tom Grenchik

Mr. Grenchik is from the Archdiocese of Washington. He read aloud the criteria from HB 1359 the Task Force was to consider in formulating a standard benefit package. He said

covering elective abortions steps outside these principles. He also said "medically necessary" is not defined in Maryland law. This language could include anything. The Task Force could use language such as "to save the life of the mother."

> Pat Kelly

Ms. Kelly is from the Maryland Catholic Conference. She said she is confused with the logic that says prescription drugs, an elementary thing everyone can use, will have to have high copays, but we must at all costs cover abortion. If the Task Force includes elective abortions, they are not providing many people a choice. People will be confronted with either paying for abortions or not paying for health care. After some discussion, Ms. Kelly said she was unaware that optional riders, such as one for elective abortions, would apply to an entire group and not be available on an individual basis.

> Mike Calsetta

Mr. Calsetta is representing the Knights of Columbus. He read a witness's description of watching an abortion from a sonogram. Mr. Calsetta said many abortions are done for convenience. He asked the Task Force not to force small business to become a part of the tragedy.

> Tom King

Mr. King said he is testifying as a private citizen. He does not understand why in-vitro fertilization is being taken away from employees but they may be forced to pay for abortions. The cost of abortion adds to the bottom line costs.

ADJOURNMENT

The meeting was adjourned at 11:50 p.m.

ATTACHMENT

STANDARD BENEFIT PLAN TASK FORCE

October 28, 1993

	<u>Indemnity</u>	<u>PPO</u>	<u>POS</u>	<u>HMO</u>	<u>Wt. Avg.</u>
	\$3,633	\$3,230	\$3,185	\$3,156	\$3,235 (target = \$3
OLD	250/500 80/20 2500/5000	250/500 90/70 2500/5000	0 80/60 1500/3000 200/400 3000/6000	\$10/\$20	
NEW	500/1000 80/20 3000/6000	(1) 500/1000 90/70 2500/5000 (2) 250/500 80/60 2500/5000	200/400 80/60 1500/3000 200/400 3000/6000	N.C.	
	\$3,295	\$2,972	\$2,978	\$3,156	\$3,061

STATE OF MARYLAND



William C. Richardson
CHAIRMAN

Alex Azar, M.D.

Harold A. Cohen

Elaine W. Johnston

J. Dennis Murray

John A. Picciotto

Marc E. Zanger

John M. Colmers
EXECUTIVE DIRECTOR

HEALTH CARE ACCESS AND COST COMMISSION

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MEMORANDUM

TO: All Interested Parties

FROM: John M. Colmers *sl*
Executive Director

DATE: November 3, 1993

RE: Release of SBPTF Report

Enclosed please find a copy of the Standard Benefit Plan Task Force Report which will be made available to the public at tomorrow's Commission meeting at 1 p.m. Public testimony will be heard on November 19th in the Metro Building, 4201 Patterson Avenue in rooms 108 and 109 and will begin at 9:00 a.m. Please feel free to contact me if you have any further questions.

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nb



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